PROVIDER*Update*

NEWS & ANNOUNCEMENTS | NOVEMBER 1, 2016 | UPDATE 16-707 | 2 PAGES

Health Net Access™

Health Net Access Transition Reminder

As a reminder, on March 24, 2016, Centene acquired Health Net, including the Health Net Access (HNA) plan. HNA providers can refer to the provider updates referenced in this update for comprehensive information regarding these changes.

CLAIMS PROCESSING

The following updates to claims processing were implemented, effective July 1, 2016. Additional information regarding these updates was communicated in provider update 16-320, *New Claims Processes for Health Net Access Transition*, distributed on June 1, 2016.

Claims Payments

You will receive payments from HNA for dates of service (DOS) prior to June 30, 2016. You will receive payments from Centene for DOS July 1, 2016, and beyond. HNA is anticipating an 18-month period of time where you may receive payments from both entities depending on the DOS.

Optical Character Recognition (OCR) of Claim Forms

The only acceptable claim forms are those printed in Flint OCR Red, J6983, (or exact match) ink. Providers may continue the use of HNA's secure online portal for electronic claims submissions by visiting www.healthnetaccess.com.

DRG Billing Changes

HNA is conducting check-run sample reviews for providers with inpatient claims using targeted diagnosis codes to ensure that claims processes related to DRG are followed.

New Claims Edits

Additional claims edits have been added in order to reduce current HNA encounters issues. Claims that do not meet the claims edit requirements will be considered non-compliant. HNA no longer accepts non-compliant claims.

PRIOR AUTHORIZATION PROCESSES

The following changes regarding prior authorization requirements and the authorization tool were implemented on July 1, 2016. Additional information regarding these changes was communicated in provider update 16-319, *Prior Authorization Process, Website Re-Registration and Vision Vendor Changes*, distributed on June 1, 2016.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- Physicians
- Medical Groups/IPAs
- Hospitals
- Ancillary Providers

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fax 1-800-937-6086

Prior Authorization Requirement Changes

Changes were made to the HNA prior authorization requirements, as described in provider update 16-319. The current HNA prior authorization requirements can be accessed on the secure Web portal at www.healthnetaccess.com.

Online Authorization Tool

HNA providers can utilize an online authorization tool to help determine whether services require plan prior authorization. To access the online tool, visit www.healthnetaccess.com and select *Pre-Auth Check.* If you are uncertain whether prior authorization is needed, submit a request for an accurate response by selecting the option "To submit a prior authorization".

WEBSITE AND PROVIDER WEB PORTAL CHANGES

Effective July 1, 2016, the HNA website has a new look; however, providers can still access the secure Web portal utilizing the same link at www.healthnetaccess.com. All HNA providers will need to re-register for access to the online secure portal. To re-register for Web portal access, visit www.healthnetaccess.com.

ENVOLVE VISION VENDOR

Effective June 1, 2016, Envolve Benefit Options (Envolve) is the HNA vision vendor. Members or their representatives can contact HNA's member services department at 1-888-788-4408 for assistance with benefits or locating a vision provider.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

Take Advantage of Health Net's Online Tools!

Visit Health Net's provider portal directly at provider.healthnet.com. Once logged in, quickly find and verify member eligibility, copayments, prior authorization requirements, and other plan details for a selected member under *Patient Information*. View his or her transaction status under *Patient History* to find what you need, when you need it.

Health Net Access
Provider Forum

Register today! Availability is limited.

Health Net Access, Inc. and the Provider Relations Department invite you to an upcoming provider forum for Health Net Access contracted providers. This is a no-cost training event designed for Health Net Access primary care physicians (PCPs), obstetricians and gynecologists (OB/GYNs), specialists, office staff, and billing teams.

Date:

Tuesday, November 15, 2016
11:00 a.m. to 1:00 p.m., Mountain time (MT)
Lunch will be provided.

Place:

Hilton Airport Phoenix
2435 South 47th Street
Phoenix, AZ 85034

RSVP:

Monday, November 7, 2016,
via fax or online, to be entered into a raffle for a gift card.

Fax: **(602) 794-1803** or sign up online at **https://www.SignUp4.net/public/ap.aspx?EID=20162457E.**

Presenters include:

Vendor Presentations

- Community Bridges
- Health Net Access Prior Authorization
- Southwest Behavioral Health
- Terros
- Health Net Access Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- Heath Net Access Minimum Subcontract Provisions

If you are unable to attend the training, materials will be available on the Health Net provider website at provider.healthnetaccess.com under *Working with Health Net > Regulatory > Health Net Access,* or you may request them from the Health Net Quality Improvement Department via email at **AHCCCS_Notification@healthnetaccess.com**.

Please register online or complete the information below and fax this form as directed above.

Attendee name (please print)	*Physician/Practice name and tax ID*	*Specialty*	*Telephone*
_____	_____	_____	_____
_____	_____	_____	_____

16-706
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PROVIDER*Update*

NEWS & ANNOUNCEMENTS | OCTOBER 24, 2016 | UPDATE 16-650 | 2 PAGES

Health Net Access™

How To Register For PaySpan Health®

As a reminder, PaySpan Health® is Health Net Access, Inc.'s, electronic payments and electronic remittance advices delivery service based on provider preferences.

Providers must continue to submit their claims through Health Net Payer ID 38309 for all claims regardless of date of service.

CLAIMS DATES OF SERVICE JULY 1, 2016, AND AFTER

To receive electronic fund transfer (EFT) and electronic remittance advice (ERA), for claims with dates of service July 1, 2016, and after, providers are required to register with PaySpan Health.

CLAIMS DATES OF SERVICE JULY 1, 2016, AND PRIOR

For claims with dates of service July 1, 2016, and prior, if providers are already registered with Health Net Access and wish to add or update a PaySpan Health registration, providers must also update the registration on Health Net Access by submitting an updated ERA/EFT registration form found on www.healthnetaccess.com > *For Providers > Submit Electronic Claims to Access > Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT)* under Register Online or Download Enrollment Forms.

REGISTER FOR PAYSPAN HEALTH

To register with PaySpan, follow the below steps:

- Visit www.Payspanhealth.com.
- Select *Register Now*.
- Enter National Provider Identifier (NPI)
- Enter the tax identification number (TIN).
- Enter billing ZIP code
- Select Submit.

If you have a registration code, enter the code, select Submit and follow the below steps:

- Enter the provider identification number (PIN).
- Enter the TIN.
- Enter NPI.
- Select *Start Registration*

Personal Info

- Provide full name, email address, telephone number, and job title.
- Designate a unique user name or use an email address.

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- Create a unique password of at least eight characters and include one capital letter, one lower case letter and a number.
- Select a challenge question, enter the answer and click the Next button to continue.

Account Setup

Provide accounting information as follows:

- Designate the account you wish to have funds deposited to and click the Next button to continue.

  Note: Providers typically use the Account Name to specify the payee designation. Each payee has a separate registration code and can therefore have a separate receiving account established. The same routing and account number can be used for multiple receiving accounts.
- Enter the routing number and account number in the specified fields. (uncheck the Enable Electronic Payment box if you do not want to register for EFT).

Verify Info

Verify the following information:

- Check the box to agree to the Services Agreement and select *Confirm*.
- Select the Back button to make any corrections.
- Read the Service Agreement then check the terms and conditions box if in agreement.
- Once account has been established, log in to the account.

Additional Registration Codes

To register additional registration codes, follow the below steps:

- Click *Your Payments (Start Here)*.
- On the right select *Add New Reg. Code*.
- Enter the registration code, PIN, TIN, and NPI or select *Atypical Service Provider* if the NPI is not known.
- Start Registration.

The Account Information Screen will appear:

- Select the Receiving Account (Bank Account) for the registration code. Use the Create New Receiving Account button to add another account.
- Agree to the Terms and Conditions by checking the box on the right.
- Select the Confirm button. This will complete the registration process.

PaySpan will send an email when registration is complete. If providers registered for EFT, verify with the bank that a minimal deposit has been made by PaySpan. Allow for a few days from registration for the funds to appear. This deposit amount will be used to confirm that electronic payments are set up appropriately through PaySpan and the bank. Providers will see this confirmation page the next time they log in to www.Payspanhealth.com using their user ID and password. The deposit does not need to be returned to PaySpan.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at www.healthnetaccess.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have any questions about the registration process or the website, please contact the PaySpan Provider Support Team by dialing 1-877-331-7154. Provider services specialists are available to assist Monday through Friday from 8 a.m. to 8 p.m. Eastern time (ET). For all other questions, contact the Health Net Access Provider Services Center at 1-888-788-4408.

PROVIDER*Update*

NEWS & ANNOUNCEMENTS | OCTOBER 20, 2016 | UPDATE 16-680 | 2 PAGES

Health Net Access™

Controlled Substance Prescription Monitoring Program Registration

As part of our commitment to the Sign Up to Save Lives campaign, Health Net Access requests that participating providers in Maricopa County register online at pharmacypmp.az.gov and participate in the Arizona Controlled Substances Prescription Monitoring Program (CSPMP). CSPMP was developed to promote public health and welfare by detecting diversion, abuse and misuse of prescription medications classified as controlled substances under the Arizona Uniform Controlled Substances Act.

Accessing patient information from CSPMP has many benefits, including:

- Improving patient care – Pharmacy monitoring reduces the risk of drug to drug interactions and adverse outcomes in patients managed by multiple providers due to complex chronic care needs.
- Improving patient safety – Many patients may see more than one prescriber, some may not inform each provider about other medications they are taking and some may engage in doctor shopping. CSPMP can help keep your patient safe and minimize diversion of prescription medication.
- Limiting prescriber liability – Checking patient medication history through CSPMP is a good practice to ensure standards of care are upheld and limit liability involved with dangerous medication combinations or high-dose prescribing, especially if a patient visits more than one prescriber.
- Accessing patient information easily – Prescribers can appoint an office designee to access their patients' medication histories from CSPMP, just like they do patient charts. This reduces prescriber time and helps to ensure patient safety and minimize liability concerns.

Attached is a checklist that explains the process of registering for and using CSPMP.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at www.healthnetaccess.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

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Registering for and Using the Controlled Substances Prescription Monitoring Program (CSPMP)	
NEW USER INSTRUCTIONS	
Step 1: Register	Register for CSPMP at pharmacypmp.az.gov. Select *Register now* and complete the New Registration information.
Step 2: Verify	After submitting the registration information, a verification email with the CSPMP identification (ID) number and verification code is sent. Follow the email link to verify your email address.
Step 3: Log in	Once you log in, you will be able to complete your registration profile with your CSPMP ID and Drug Enforcement Administration (DEA) number. Fill out the Registration Details and certify that the application is complete and accurate, then select *Print Certificate*.
ACCESSING PATIENT INFORMATION	
Step 1: Register	Log in to pharmacypmp.az.gov and follow the appropriate *Accessing the data* link for medical practitioners or pharmacists. A New Registration form pops up. Complete the form and submit.
Step 2: Confirm	Once completed, your access registration will be confirmed and you will receive a user name and password via email, usually within 24 to 48 hours. Exception: If you are a provider with a nonresident medical license, you must print your access registration, read and sign the Privacy Statement, and have it notarized. Mail both documents along with a copy of your nonresident medical state license and driver's license. Once received and processed, a user name and password will be emailed to you.
Step 3: Log in	When you receive your user name and password, you will be able to log in to the CSPMP.
REQUESTING PATIENT INFORMATION	
Step 1: Request	Log in to the CSPMP. Under the Request tab at the top left of the screen, select *New Request* and then complete the request form.
Step 2: Open	The requested information is sent as a PDF attachment.

PROVIDER*Update*

NEWS & ANNOUNCEMENTS | OCTOBER 17, 2016 | UPDATE 16-679 | 1 PAGE

Health Net Access™

AHCCCS Electronic Health Records Incentive Program – 2nd Notice

As a reminder, eligible professionals (EPs) must register and submit an attestation with the Arizona Health Care Cost Containment System (AHCCCS) at www.azepip.gov/ by December 31, 2016, to participate in the Medicaid Electronic Health Records (EHR) Incentive Program.

The EHR Incentive Program provides incentive payments to eligible Medicaid health care providers who adopt and use EHR technology in ways that may positively affect patient care. EPs may receive Medicaid EHR incentive payments for up to six years (may total up to $63,750). The final year for Medicaid EHR incentive payments is 2021.

There are many benefits to providers utilizing EHR technology. For example, having a certified EHR allows providers to transition from paper records and having to fax clinical information to secure electronic data recording and sharing. The real time clinical patient information supports providers who want to improve care coordination and patient health outcomes. As a result, Health Net Access, Inc. is encouraging all eligible providers to participate in the EHR Incentive Program.

AHCCCS awarded a contract to Arizona Health-e Connection (AzHeC), a statewide non-profit organization that is driving the adoption and optimization of health information technology (HIT) and health information exchange (HIE), to provide limited, no-cost education and assistance to Medicaid providers who are interested and may qualify for the Medicaid EHR Incentive Program. To take advantage of this limited, no-cost education opportunity and to learn more about the Medicaid EHR Incentive Program, contact AzHeC at (602) 688-7200 or via email at EHR@azhec.org.

For additional information and a quick reference guide to get started, go to the AHCCCS EHR Incentive Program webpage at https://azahcccs.gov/PlansProviders/CurrentProviders/EHR/.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at www.healthnetaccess.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

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PROVIDER*Update*

NEWS & ANNOUNCEMENTS | OCTOBER 12, 2016 | UPDATE 16-644 | 2 PAGES

Health Net Access™

2016–2017 Influenza Vaccine Recommendations

On August 26, 2016, the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) released the Prevention and Control of Influenza with Vaccines Report regarding the use of vaccines to prevent and control influenza for the 2016–2017 season.

The comprehensive ACIP report is available online at http://www.cdc.gov/mmwr/volumes/65/rr/rr6505a1.htm?s_cid=rr6505a1_w and includes complete influenza vaccine recommendations for the 2016–2017 season. The information in this update highlights some, but not all, documentation of the report.

VACCINE HIGHLIGHTS

Routine annual influenza vaccinations are recommended for all persons ages 6 months and older who do not have contraindications to vaccine use. Health care providers should begin offering vaccinations as soon as they become available. The vaccine should continue to be offered throughout the flu season as long as it is available since influenza may not appear in certain communities until May.

Additional information from the ACIP report includes the following topics for the 2016–2017 season:

- Groups recommended for vaccinations and timing of vaccinations.
- Available vaccine products and indications, including new vaccine licensures.
- Vaccine dose considerations for children ages 6 months through 8 years.
- The use of live attenuated influenza vaccine (LAIV) is no longer recommended due to low effectiveness in recent flu seasons.
- Recommended influenza vaccination settings for individuals with a history of egg allergies.
- Vaccine selection and timing of vaccinations for immunocompromised individuals.

Different influenza vaccine preparations have different indications as licensed by the U.S. Food and Drug Administration (FDA). For the most current information regarding influenza vaccine recommendations, visit the CDC website at www.cdc.gov/flu.

INFLUENZA VACCINE COMPOSITION FOR 2016–2017

U.S. trivalent influenza vaccines for 2016–2017 contain an A/California/7/2009 (H1N1)-like virus, an A/Hong Kong/4801/2014 (H3N2)-like virus and a B/Brisbane/ 60/2008-like virus (Victoria lineage). Quadrivalent influenza vaccines also contain B/Phuket/ 3073/2013-like virus (Yamagata lineage), which is the same strain used in trivalent formulations the previous season.

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VACCINE DISTRIBUTION AND ORDERING INSTRUCTIONS

The influenza vaccine is being distributed through local vendors and distributors. For the 2016–2017 season, most preparations are available for purchase. Information about distributors who have influenza vaccines is available online at www.preventinfluenza.org.

CLAIM SUBMISSION FOR THE INFLUENZA VACCINE

Health Net Access, Inc. reimbursement to providers is in accordance with the terms of the provider's Health Net *Provider Participation Agreement* (*PPA*) and the member's benefit plan design.

COLORECTAL CANCER SCREENING RATES DURING FLU SEASON

Colorectal cancer is the second leading cause of cancer death and has the third highest cancer incidence rate despite being highly preventable through colorectal cancer screenings. Health Net is participating in a national campaign to increase colorectal cancer screening to 80% by 2018. Providers are encouraged to discuss colorectal cancer screening with patients missing this important screening during visits for flu vaccinations and throughout the flu season. To learn more about the FLU/FIT initiative to hand out fecal immunochemical test (FIT) kits when patients come in for their flu vaccine, visit http://www.flufit.org/. Similar to flu vaccinations, remind patients that screenings via FIT must also be done annually. Providing patients screening options has been shown to improve participation, and a physician recommendation is the strongest factor associated with patient willingness to have a screening.

ADDITIONAL INFORMATION

Providers are encouraged to access the Health Net Access provider portal online at www.healthnetaccess.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

PROVIDER*Update*

NEWS & ANNOUNCEMENTS | OCTOBER 4, 2016 | UPDATE 16-654 | 3 PAGES

Health Net Access™

Zika Virus Preparedness

In accordance with an Arizona Health Care Cost Containment System (AHCCCS) request, Health Net Access, Inc. is assisting the Arizona Department of Health Services (ADHS) in notifying providers about the prevention of Zika virus through patient education.

Attached are ADHS's memo on the Zika virus and a provider reference sheet for discussing Zika prevention with patients.

ADDITIONAL INFORMATION

Providers may access the provider portal online at www.healthnetaccess.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

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ARIZONA DEPARTMENT OF HEALTH SERVICES

PREPAREDNESS

September 20, 2016

To AHCCCS Providers:

To date, Arizona has had over 30 travel-associated cases of Zika, and 0 locally-acquired cases.

Arizona is considered to be a high-risk state for Zika, given the endemicity of the *Aedes aegypti* mosquito, the number of travelers returning from Zika-affected countries, and the occurrence of similar mosquito-borne disease outbreaks in the past.

Arizona clinicians play a crucial role in educating patients in order to prevent local transmission of Zika and the subsequent effects to Arizonans and their children.

- **First, clinicians need to discuss prevention with their patients**. Zika prevention messages overlap with those for maternal/child health, sexual health, and vector-borne diseases, and should easily fit into a physician's typical counseling. Specialized messages do pertain to pregnant women and all individuals traveling to Zika-affected areas. Resources for preventive messages include a one-pager (attached) and the CDC prevention website.

- **Second, clinicians need to coordinate with public health if there is concern for Zika**. Public health departments across Arizona are the subject matter experts for Zika transmission, diagnosis and management. The Arizona State Public Health Laboratory can perform the complete testing cascade for eligible patients, at no charge. Algorithms for determining Zika testing eligibility and contacts for local health departments are available.

Zika is but the most recent threat to Arizona's health. Arizona clinicians and public health must communicate what they are seeing in clinic and the community, respectively. Clinicians can sign up for the Arizona Health Alert Network or download the Arizona-based IDAZ Mobile App to receive statewide alerts and to call public health with a single click.

ARIZONA DEPARTMENT OF HEALTH SERVICES

PREPAREDNESS

Zika Prevention Messages for Patients

There is currently **no local spread** of Zika in Arizona. Providers can reduce the risk that Arizonans get exposed to Zika through the use of patient-specific prevention messages.

Zika prevention should be discussed at EVERY VISIT with women of reproductive age (pregnant and nonpregnant).

PREGNANT WOMEN *(AZ population: 99,000)*

1. **Avoid travel to areas with Zika.** Reference the map of Zika-affected areas at www.cdc.gov/zika/geo.
2. **Avoid mosquito bites**. Reassure that DEET is safe in pregnancy.
3. **Avoid unprotected sex with partners who traveled to areas with Zika.** Recommend abstinence or regular condom use for the duration of pregnancy.

WOMEN OF REPRODUCTIVE AGE *(AZ population: 1.2 million)*

1. **Avoid unplanned pregnancies**. Address the reproductive life plan of every woman at every visit.
2. **Time pregnancies safely**. Advise delaying attempts at conception for 8 weeks if the woman was exposed or diagnosed with Zika, 8 weeks if the man was exposed to Zika, and 6 months if the man was diagnosed with Zika.
3. **Avoid mosquito bites**. Recommend DEET, long sleeves and window/door screens.

ALL PATIENTS *(AZ population: 6.7 million)*

1. **Avoid mosquito bites in areas with Zika**. Recommend DEET, long sleeves and window/door screens. Avoid insect repellents in children <2 months old.
2. **Avoid mosquito bites here after returning from areas with Zika**. Recommend DEET, long sleeves and screens for the first three weeks back from travel. Avoid insect repellents in children <2 months old.
3. **Control mosquitos inside and outside the home**. Advise dumping all resting water (down to the size of a bottle cap) around the home.

Further prevention resources: www.cdc.gov/zika/prevention; Physician Zika testing algorithms for Arizona: www.azhealth.gov/zika; Local health department contacts: www.azdhs.gov/localhealth.

Last Updated: 09/09/16

PROVIDER*Update*

CONTRACTUAL | SEPTEMBER 30, 2016 | UPDATE 16-630 | 1 PAGE

Changes to the Medical Record Review Process

Beginning October 2016, Health Net Access, Inc., through its association with the Arizona Association of Health Plans (AzAHP) and along with other health plans across Arizona, will contract with Advantmed to perform annual medical record reviews. Medical record reviews are performed every three years for each primary care physician (PCP), pediatrican and OB/GYN provider meeting Arizona Health Care Cost Containment System (AHCCCS) requirements.

Health Net Access will provide Advantmed a list of its contracted PCPs, pediatricians and OB/GYN providers and members who have been seen by those providers. Advantmed randomly selects from the combined lists, and requests to pull a sample of medical records for each individual provider. Advantmed uses a standard AHCCCS-approved audit tool developed by the participating health plans to conduct medical record reviews. Providers scoring 90 percent or better on the first eight medical records will have no further review. If the score is less than 90 percent, Health Net Access will educate the provider on the deficiencies and schedule another review in one year.

Providers undergoing this medical record review process only need to participate in one medical record review. The review is used to represent all participating AHCCCS health plans rather than one for each of the individual plans. Medical reviews for PCPs, pediatricians and OB/GYN providers are performed once every three years, unless the provider does not meet the required score to pass, in which case the provider will undergo a review the following year.

Advantmed will send Health Net Access PCPs, pediatricians and OB/GYN providers a letter in advance of the medical record review. The Health Net Access Quality Management Department strongly encourages providers to cooperate fully with the review process.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at www.healthnetaccess.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

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PROVIDER*Update*

CONTRACTUAL | SEPTEMBER 29, 2016 | UPDATE 16-618 | 1 PAGE

Health Net Access™

Provider Demographic Data Verification Reminder

To ensure Health Net Access, Inc. members have access to accurate information when selecting providers, providers are required to provide advance notification to Health Net Access, their medical groups or independent practice associations (IPAs) when they have changes to their demographic information. On a monthly basis, providers should validate that their demographic information is reflected correctly on the provider website at www.healthnet.com under ProviderSearch.

DEMOGRAPHIC INFORMATION

Providers' demographic data 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 Access must notify Health Net Access of changes by completing the online form or by reaching out to their provider network administrator (PNA). The online form is available on the provider website at provider.healthnet.com under *My Account > Profile > Update Provider Information.* Providers must have the *Update Provider Information* privileges to update and submit changes online.

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 Access. Medical groups and IPAs must have policies in place that establish and implement processes to collect, maintain and submit their provider demographic changes to Health Net Access on a real-time basis. Real-time is within 30 days, as recently defined by the Centers for Medicare & Medicaid Services (CMS). Health Net Access conducts random audits of medical groups and IPAs to validate processes and policies to ensure they are maintaining provider demographic information on a regular basis.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- Physicians
- Medical Groups/IPAs
- Hospitals
- Ancillary Providers

PROVIDER SERVICES

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602.794.1400
888.788.4408
www.healthnet.com

Date

<Entity Name>
<First name> <Last name>, <Title> *or* Administrator
<Address>
<City>, <State> <ZIP>

Dear <Title>. <Last Name> *or* Administrator:

Enclosed are two documents requiring your attention. The first document is a unilateral regulatory amendment to your Health Net Access, Inc. *Provider Participation Agreement* (*PPA*), pertaining to the updated website address for Arizona Health Care Cost Containment System (AHCCCS) Minimum Subcontract Provisions (MSPs). Please file this amendment with your copy of the *PPA*. No further action is necessary on your part. The second document is a Disclosure of Ownership and Control Interest Statement form, which you must complete and return to Health Net Access within 30 days of this letter.

In accordance with Title 42 of the Code of Federal Regulations (CFR) 455.104, 455.105 and 455.106, Health Net Access requires providers who are entering into or renewing a *PPA*, to complete the enclosed Disclosure of Ownership and Control Interest Statement form. When there are changes to the information disclosed on this form, providers must complete and submit an updated form to Health Net Access within 30 days of the change. You may attach a separate sheet as necessary to provide complete information.

Providers may fax the completed form to (602) 794-1803 or mail it to:

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

Failure to return the form within the time frame may result in termination of participation in the Health Net Access provider network.

Thank you for participating in Health Net Access. We appreciate your service to our members. If you have any questions, please contact the Health Net Access Provider Services Center at 1-888-788-4408.

Sincerely,

Provider Network Management

Enclosures

REGULATORY AMENDMENT
to the
PROVIDER PARTICIPATION AGREEMENT
between
HEALTH NET OF ARIZONA, INC.
and
PROVIDER

The Provider Participation Agreement ("Agreement"), as subsequently amended, between Provider and Health Net of Arizona, Inc. on behalf of itself and the subsidiaries and affiliates of Health Net, Inc. (collectively "Health Net"), is hereby further amended effective August 1, 2016 ("Effective Date").

RECITALS

WHEREAS, Health Net Access is updating the AHCCCS minimum subcontract provision website;

WHEREAS, Health Net and Provider desire to amend the Agreement to:

Amend the Health Net Access addendum only.

NOW THEREFORE, in consideration of the mutual considerations contained in this Amendment, both parties hereby agree to amend the Agreement as follows:

Addendum F shall be deleted in its entirety and replaced with the attached Addendum F, Medicaid Provisions.

ADDENDUM F

MEDICAID PROVISIONS

Provider understands and agrees that (i) the obligations of "Contractor" and of "Health Net" set forth in this Addendum shall be the obligations of Health Net Access, Inc., and not the obligations of Health Net, Inc. or any other Affiliate of Health Net, Inc. and (ii) the obligations of "Subcontractor" shall be the obligations of Provider. To the extent that any definition, term, condition or provision set forth in this Addendum is inconsistent or in conflict with any definition, term, condition or provision set forth in the Agreement, the definition, term, condition or provision set forth in this Addendum shall control with respect to the Medicaid AHCCCS Benefit Program.

The following provisions are required pursuant to Arizona law to be included in this addendum/attachment verbatim.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
Minimum Subcontract Provisions

The provisions referred to by AHCCCS as "Minimum Subcontract Provisions", including all subsequent updates published by AHCCCS, apply to Provider and are fully set forth in the following internet link:

https://azahcccs.gov/PlansProviders/HealthPlans/minimumsubcontractprovisions.html

Health Net Access™

Disclosure of Ownership And Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to Health Net Access within 30 days of the change. Please attach a separate sheet if necessary to provide complete information.

Practice Information

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity
Name of Individual, Group Practice, or Disclosing Entity:
DBA Name:
Address:
Federal Tax Identification Number: Provider CAQH #:

Section I

For individuals, list the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.

For entities, list the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary.(42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section II

Are any of the individuals listed above related to each other? ☐ Yes ☐ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Type of relation

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? ☐Yes ☐ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

<TIN#>

Health Net Access™

Disclosure of Ownership And Control Interest Statement

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? ☐ Yes ☐ No (verify through IUIS-OIG Website)

If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more that $25,000 or any significant business transactions with any subcontractors? ☐ Yes ☐ No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5-year period. (42 CFR 455.105).
Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information 1) as a Disclosing Entity? ☐ Yes ☐ No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature _____ **Title (or indicate if authorized Agent)** _____

Name (please print) _____ **Date** _____

Please return the form by fax to (602) 794-1803 or by mail in the enclosed postage paid envelope to:

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

<TIN#>

PROVIDER*Update*

NEWS & ANNOUNCEMENTS | SEPTEMBER 12, 2016 | UPDATE 16-591 | 1 PAGE

Health Net Access™

AHCCCS Electronic Health Records Incentive Program

The Arizona Health Care Cost Containment System (AHCCCS) Electronic Health Records (EHR) Incentive Program provides incentive payments to eligible Medicaid health care providers who adopt and use EHR technology in ways that may positively affect patient care.

Eligible professionals (EPs) may receive Medicaid EHR incentive payments for up to six years (may total up to $63,750). The final year for Medicaid EHR incentive payments is 2021. However, EPs must submit an attestation with AHCCCS by December 31, 2016.

There are many benefits to providers utilizing EHR technology. For example, having a certified EHR allows providers to transition from paper records and having to fax clinical information to secure electronic data recording and sharing. The real time clinical patient information supports providers who want to improve care coordination and patient health outcomes. As a result, Health Net Access, Inc. is encouraging all eligible providers to participate in the EHR Incentive Program.

AHCCCS awarded a contract to Arizona Health-e Connection (AzHeC), a statewide non-profit organization that is driving the adoption and optimization of health information technology (HIT) and health information exchange (HIE), to provide limited, no-cost education and assistance to Medicaid providers who are interested and may qualify for the Medicaid EHR Incentive Program. To take advantage of this limited, no-cost education opportunity and to learn more about the Medicaid EHR Incentive Program, contact AzHeC at (602) 688-7200 or via email at EHR@azhec.org.

For additional information and a quick reference guide to get started, go to the AHCCCS EHR Incentive Program webpage at https://azahcccs.gov/PlansProviders/CurrentProviders/EHR/.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at www.healthnetaccess.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

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PROVIDER*Update*

CONTRACTUAL | SEPTEMBER 1, 2016 | UPDATE 16-560 | 1 PAGE

Health Net Access™

Health Net Access Program Changes

This communication provides information on long-acting reversible contraception (LARC) device claims coding, changes in podiatry coverage and reminder on Arizona KidsCare coverage.

LONG-ACTING REVERSIBLE CONTRACEPTION DEVICE CLAIMS BILLING

Effective October 1, 2016, Arizona Health Care Cost Containment System (AHCCCS) pays hospitals for LARC devices in addition to diagnosis-related group (DRG) payment methodology. **Hospitals are required to bill for LARC devices on the CMS-1500 form using the below codes**. Hospitals must not use the UB-04 (CMS-1450) claim forms to bill for LARC devices.

- J7297 – Levonorgestrel-releasing intrauterine contraceptive system, 52mg, 3 year duration
- J7298 – Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration
- J7300 – Intrauterine copper contraceptive
- J7301 – Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg
- J7307 – Etonogestrel (contraceptive) implant system, including implant and supplies

CHANGE IN PODIATRY SERVICES COVERAGE

AHCCCS expanded its coverage of podiatry services. Effective October 1, 2016, podiatry services performed by a licensed podiatrist, pursuant to A.R.S. Title 32, Chapter 7, are covered for all Health Net Access members when ordered by a primary care physician or primary care practitioner.

KIDSCARE COVERAGE REMINDER

As a reminder, KidsCare coverage is now available for children ages 18 or younger in households that are between 133 percent and 300 percent of the federal poverty level (FPL). The KidsCare enrollment application and instructions are available online at www.azahcccs.gov/Members/GetCovered/apply.html or patients may apply directly online at www.healthearizona.org/app/Default.aspx.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at www.healthnetaccess.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

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PROVIDER*Update*

CONTRACTUAL | AUGUST 23, 2016 | UPDATE 16-523 | 1 PAGE

Health Net Access™

Updated Link to AHCCCS Minimum Subcontract Provisions

The Arizona Health Care Cost Containment System (AHCCCS) has updated its website for Minimum Subcontract Provisions (MSPs). MSPs are now available online at azahcccs.gov/PlansProviders/HealthPlans/minimumsubcontractprovisions.html.

Changes to AHCCCS MSPs automatically amend providers' Health Net Access, Inc. *Provider Participation Agreements (PPAs)*. Providers are encouraged to check for updated MSPs on the AHCCCS website frequently.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at www.healthnetaccess.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

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PROVIDER*Update*

CONTRACTUAL | AUGUST 12, 2016 | UPDATE 16-504 | 3 PAGES

Health Net Access™

Medical Policies – 2nd Quarter 2016

This provider update includes a listing of updated Health Net Access, Inc. (Health Net) medical policies approved by the Health Net National Medical Advisory Council (MAC) in the second quarter of 2016. For a complete description of new and updated medical policies, visit the Health Net provider website at provider.healthnet.com and select *Working with Health Net > Medical Policies*.

PURPOSE OF HEALTH NET MEDICAL POLICIES

Medical policies provide guidelines for determining medical necessity for specific procedures, equipment and services. All services must be medically necessary to be eligible for benefit coverage, unless otherwise defined in the member's benefits contract. The determination for coverage is also based on all of the terms of the individual member's benefits contract, including, but not limited to, eligibility at the time of service and description of covered benefits, limitations and exclusions. In some cases, legal or regulatory mandate requirements may be applicable and may prevail over medical policy. To the extent there are any conflicts between medical policy guidelines and applicable benefit contract language, the benefit contract language prevails. Medical policy is not intended to override the *Member Handbook* or the health insurance policy that defines the member's benefits, nor is it intended to provide medical advice or dictate to providers how to practice. If required, prior authorization must be obtained before services are rendered.

Updated Policies

Policy	Change
CARDIAC DEFIBRILLATORS – EXTERNAL	Revised policy statement to reflect IIa and IIb recommendations from the American Heart Association (AHA) Science Advisory on wearable cardioverter-defibrillator (WCD) therapy.
CIRCUMFERENTIAL ENDOSCOPIC RFA OF BARRETT'S ESOPHAGUS	Removed the following from policy statement on treatment of confirmed Barrett's esophagus with low-grade dysplasia: "when the physician deems the individual at increased risk for progression to high-grade dysplasia or esophageal cancer."
CONTINUOUS GLUCOSE MONITORING DEVICES	Revised policy to consider use of a U.S. Food and Drug Administration (FDA)-approved artificial pancreas device system with a low-glucose suspend feature (low-glucose suspend system/threshold suspend device system (MiniMed® 530G/MiniMed 530G with Enlite™) medically necessary in patients ages 16 and older with type 1 diabetes who meet the criteria for long-term use of combined continuous

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Updated Policies, continued

Medical Policy	Change
CONTINUOUS GLUCOSE MONITORING DEVICES, CONTINUED	subcutaneous insulin infusion and blood glucose monitoring systems. All other artificial pancreas device systems, including, but not limited to, control-to-range and control-to-target systems, remain investigational.
ELECTRIC TUMOR TREATMENT FIELDS (OPTUNE DEVICE FORMERLY KNOWN AS NOVOTTF-100A)	Added Optune® with temozolomide for treatment of adult patients (over age 22) with newly diagnosed and histologically confirmed, supratentorial glioblastoma multiform (GBM) following maximal debulking surgery and completion of radiation therapy together with concomitant standard of care as investigational as there is a paucity of supporting peer-reviewed literature. Included National Comprehensive Cancer Network® (NCCN) (v1.2015) category revision for treatment for GBM recurrence, the diffuse or multiple and local pathways with the option to consider alternating electric field therapy for glioblastoma.
GENDER REASSIGNMENT SURGERY	Defined the minimum recommended credentials for professionals who work with individuals presenting with gender dysphoria, and minimum-required credentials for those providing consultative evaluations for gender reassignment surgery as psychiatrists or clinical psychologists (Master's level minimum, with PhD or PsyD preferred) or those with commensurate experience as noted in the policy.
HER2/NEU (FORMERLY HER2/NEU HERCEPTIN®)	Added updated 2015 College of American Pathology (CAP) and NCCN guidelines to algorithms to clarify positive, equivocal, negative, and indeterminate HER2 results. Added HER2/neu testing as medically necessary for first recurrences of breast cancer, whenever possible, per NCCN (v2.2016) Breast Cancer guidelines. Added that trastuzumab should be added to chemotherapy for HER2/neu overexpressing of esophageal and esophagogastric metastatic adenocarcinoma, per NCCN (v1.2016) Esophageal and Esophagogastric Junction Cancers guidelines.
HYPERBARIC OXYGEN THERAPY (HBOT)	Added hyperbaric oxygen therapy (HBOT) as medically necessary with pneumatosis cystoides intestinalis and prophylactic pre- and post-treatment for individuals undergoing dental surgery of radiated jaw. Added that HBOT may be necessary, in specific situations, for premature infants with birth prior to 37 weeks gestation or weight less than 3.3 pounds.
IMPLANTABLE CARDIAC EVENT MONITORS	Added that implantable event cardiac monitors would be considered medically necessary when used on a case-by-case basis only in a small subset of individuals with severely significant and suspected paroxysmal atrial fibrillation as a cause of cryptogenic stroke when other less invasive diagnostic modalities, such as external ambulatory event monitors or Holter monitors, have been used with inconclusive results.
INTERSPINOUS PROCESS DECOMPRESSION SYSTEM (X-STOP, COFLEX INTERLAMINAR STABILIZATION DEVICE)	Policy statement revised to note that all interspinous process decompression systems (X-Stop, Coflex® Interlaminar Stabilization® device), as well as other similar procedures for the treatment of symptomatic lumbar spinal stenosis, are considered investigational due to lack of sufficient evidence in the published peer-reviewed literature regarding their long-term safety and efficacy.

Updated Policies, continued

Medical Policy	Change
MOLECULAR TUMOR MARKERS FOR NON-SMALL CELL LUNG CANCER	Added under EGFR testing, "Osimertnib is recommended as subsequent therapy as a treatment option for patients with metastatic EGFR T790M mutation-positive tumors, as determined by FDA-approved tests or other validated laboratory-developed tests performed in a CLIA-approved laboratory, such as cobas EGFR Mutation Test v2." Revised statement regarding NCCN recommendation in policy statement, "EGFR mutation testing should be done as part of multiplex mutation screening assay or next-generation sequencing (NGS)," to, "testing should be done as part of broad molecular profiling." Added GeneStrat test as investigational.
PHARMACOGENETIC TESTING	Added genotyping for statin-associated myopathy (SLCO1B1) as investigational.
PROPHYLACTIC MASTECTOMY	Per NCCN (v2.2016) on Genetic/Familial High-Risk Assessment: Breast or Ovarian: genetic mutation, added PALB2 as an option for risk reduction mastectomy, based on gene and risk level.
STEM CELL TRANSPLANTATION IN ADULTS	Added changes based on NCCN: • Acute myeloid and lymphoblastic leukemia (v1.2016) – Added HLA typing for patient with potential HCT in future (except for patients with major contraindications to HCT). • Acute myeloid leukemia (v1.2016) – Added patients who are deemed as strong candidates for SCT and have available donor should be transplanted in first remission. • Hodgkin's disease (v1.2016) – Added patients in complete response after second line therapy have improved outcomes following high-dose therapy (HDT)/autologous stem cell rescue (ASCR); in selected patients, brentuximab vedotin can be used as second line therapy prior to HDT/ASCR to minimize the use of more intensive chemotherapy. • Chronic myelogenous leukemia (v1.2016) – Added the selection of tyrosine-kinase inhibitor (TKI) is based on prior therapy and/or mutational testing. There are some data regarding the efficacy of second generation TKIs against specific mutations. • Myelodysplastic syndrome (v1.2016) – Added to consider second transplant or donor lymphocyte infusion (DLI) immune-based therapy for appropriate patients who had a prolonged remission after first transplant.
TESTING FOR DRUGS OF ABUSE	Revised policy to note that it is applicable to specific levels of care, including partial hospitalization program (PHP), intensive outpatient program (IOP), recovery support group (RSG), residential treatment center (RTC), and subacute detoxification and testing as part of office-based treatment. It is not applicable to inpatient treatment.
WHEELCHAIRS AND OTHER MOBILITY DEVICES	Revised and reformatted policy to reflect recommendations from Medicare local coverage determinations (LCDs) on power mobility devices, manual wheelchair bases and wheelchair options and accessories.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

PROVIDER*Update*

CONTRACTUAL | AUGUST 10, 2016 | UPDATE 16-512 | 2 PAGES

Health Net Access™

Neonatal Abstinence Syndrome Assessment and Management

There is increasing concern regarding opioid use during pregnancy, which can result in neonatal abstinence syndrome (NAS) in newborns. Health Net Access, Inc. is working to improve identification of pregnant women using substances that may be harmful to their babies, including prescription opioids, and has developed interventions to improve health outcomes for pregnant women and their infants.

A large number of patients do not consider prescription medications to be substances that may be harmful to their babies. Therefore, it is important to engage in face-to-face discussions, with all female patients of childbearing age, about the various types of substances and ways they can impact the fetus; even with women who deny or do not report such use.

In accordance with Senate Bill (SB) 1283 (2016), providers should also review the Controlled Substance Prescription Monitoring Program (CSPMP) for all pregnant members at https://pharmacypmp.az.gov.

PHARMACY HOME PROGRAM

Providers who believe a Health Net Access member may be overusing or misusing controlled substances should refer the member for potential enrollment into the Health Net Access Pharmacy Home Program, by notifying the member's care manager or calling Health Net Access at 1-888-788-4408. The Pharmacy Home Program allows a member to be restricted to an exclusive prescriber or pharmacy based on a history of abuse or overuse of abusable medications.

CARE MANAGEMENT PROGRAM

The Health Net Access Care Management Program can assist providers with pregnant members who are using illicit substances or prescription opioids and newborns with NAS. For care management referral or for more information regarding substance-exposed newborns and NAS, contact Health Net Access via email at cmaccess@healthnet.com or via fax at 1-855-825-6146.

All providers are encouraged to coordinate substance issues with all other providers and Health Net Access.

CARING FOR PREGNANT MEMBERS

Providers caring for pregnant members should:

- Consider possible substance use, including prescription opioids.
- Discuss the consequences of substance use and prescription opioid use with all pregnant women and explain the risk of NAS for infants exposed to opioids during pregnancy.
- Include information about illicit substance use and prescription opioid use during pregnancy on the American Congress of Obstetricians and Gynecologists (ACOG)

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- ● Physicians
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Antepartum Form available on the ACOG website at www.acog.org. Send the completed ACOG form via email to cmaccess@healthnet.com or fax to 1-800-956-0721. Be sure to clearly document all identified substance use concerns. All referrals are reviewed by a perinatal triage registered nurse (RN). All high-risk pregnant members are case-managed by a skilled social worker or RN throughout the perinatal and postpartum periods.

- Refer all pregnant Health Net Access members with substance use issues to the High-Risk Perinatal Care Management program, which will assist with coordination of care and facilitate collaboration between the primary care physician (PCP) and other providers, and provide the member with education, support and resources.
- Coordinate with any other providers who are prescribing opioid medications during pregnancy, such as behavioral health providers or pain management providers. Utilize medical release of information forms as appropriate for co-management.

CARING FOR NEONATES

Arizona Revised Statutes (ARS) § 13-3620 require a health care professional, who reasonably believes that a newborn infant may be affected by the presence of alcohol or a drug, to immediately report this information to Child Protective Services. For reporting purposes, *newborn infant* means a newborn infant who is under age 30 days. Providers caring for newborn infants should also conduct the following:

- Implement a screening protocol for NAS and ensure all staff and providers are trained on the protocol.
- Consider possible NAS when signs and symptoms of substance exposure and/or withdrawal are present, even if there is not a confirmed history of substance use or opioid addiction in the mother.
- Implement a scoring and treatment protocol for NAS according to nationally established best practices and ensure all staff and providers are trained on the protocol.
- Use non-pharmacological treatment for NAS first, followed by pharmacological treatment when warranted.
- Ensure correct coding is used. Use the appropriate ICD-10 diagnosis codes that reflect the member's situation/condition, such as P96.1 or P96.2, for dates of service on and after October 1, 2015. For dates prior to October 1, 2015, use ICD-9 coding.
- Refer infants with NAS to Health Net Access Care Management for assistance with coordination of care, resources, support, and parental education.
- In accordance with state law, report infants with NAS to the Arizona Department of Child Safety on the website at https://dcs.az.gov or via telephone at 1-888-767-2445.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

Online Medical Policies

Health Net develops evidence-based medical policies through critical appraisal of current published peer-reviewed medical literature to support providers in determining medical necessity for specific procedures, equipment and services. Medical policies are located on the Health Net provider website at provider.healthnet.com under *Working with Health Net > Clinical > Medical Policies.*

PROVIDER*Update*

CONTRACTUAL | AUGUST 9, 2016 | UPDATE 16-498 | 1 PAGE

Health Net Access™

Licensed Board-Certified Behavior Analysts Registration Requirements

Licensed and credentialed board-certified behavior analysts (BCBAs) who are currently working under an Arizona Health Care Cost Containment System (AHCCCS)-registered provider and contracting with Health Net Access, Inc. must submit a provider registration packet to AHCCCS no later than August 15, 2016. Effective for dates of service on and after October 1, 2016, providers will not be able to submit claims for BCBA services unless the rendering provider is an active AHCCCS-registered BCBA provider.

BCBAs who would like to practice independently and submit claims for Health Net Access members starting on October 1, 2016, and not currently employed by an AHCCCS-registered provider, must be credentialed and contracting with Health Net Access in addition to being registered through AHCCCS. In order to submit claims for AHCCCS fee-for-service (FFS) programs, an active unrestricted license in the state of Arizona and an active AHCCCS provider registration number is required.

The provider registration application and instructions are available online at www.azahcccs.gov/PlansProviders/CurrentProviders/packet.html.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at www.healthnetaccess.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update or need additional information regarding the provider registration process, contact the Health Net Access Provider Services Center at 1-888-788-4408 or contact your provider relations representative.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- ● Physicians
- ● Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

PROVIDER SERVICES

az_internetproviderinquiries@healthnet.com
1-888-788-4408
www.healthnet.com

PROVIDER DISPUTES

Health Net Access Provider Disputes
1230 W Washington Street, Ste. 401
Tempe, AZ 85281

STATE FAIR HEARINGS

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NATIONAL PROVIDER COMMUNICATIONS

provider.communications@healthnet.com
fax 1-800-937-6086

PROVIDER*Update*

CONTRACTUAL | JULY 29, 2016 | UPDATE 16-488 | 1 PAGE

Health Net Access™

Payment and Coverage Policies Online

Effective August 1, 2016, Health Net Access, Inc., a Centene Corporation company, will publish Payment & Coverage policies to the website at www.healthnetaccess.com.

The Centene Corporation Payment Integrity Unit established a Payment & Coverage Policy initiative in an effort to improve quality of care and enhance provider communication related to plan payment policies. The initiative was designed to increase claims processing efficiency and effectiveness to better ensure payment of only correctly coded and medically necessary claims.

Payment & Coverage policies address coding inaccuracies, such as unbundling, fragmentation, upcoding, duplication, invalid codes, and mutually exclusive procedures, as well as statements of plan coverage of items and services. Coding and billing rules applied are based on industry standards and guidelines as published and defined in the Current Procedural Terminology (CPT), Centers for Medicare & Medicaid Services (CMS) and public domain specialty society edits. State contract and/or state-specific regulations are accounted for in the policies.

Health Net Access maintains a robust policy library on the website outlining payment and coverage rules related to different procedures. Health Net Access encourages providers to check the website at www.healthnetaccess.com often as policies are reviewed and uploaded throughout the year.

Providers may contact their provider relations representatives for assistance in accessing policies or request polices to be provided in a different format.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at www.healthnetaccess.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

Enroll for Electronic Payment and Remittance

Enroll for electronic remittance advice (ERA) and electronic funds transfer (EFT) to reduce administrative work and check-processing expenses, and expedite payment and remittance receipt. ERA requires you to also enroll with your clearinghouse. Enrollment forms for ERA and EFT are available online at provider.healthnet.com under *Working with Health Net > EDI > Transfer Funds Electronically*.

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PROVIDER*Update*

CONTRACTUAL | JULY 21, 2016 | UPDATE 16-391 | 3 PAGES

Health Net Access™

Language Assistance Program and Cultural Competency

Health Net Access, Inc. offers participating physicians, medical groups, ancillary providers, and members 24-hour access to telephonic interpreter services. Additionally, Health Net Access offers in-person interpreter services, as well as sign language assistance, during business hours at no cost.

INTERPRETER SERVICES

Health Net Access provides interpreter support for limited-English proficient (LEP) members at all medical points of contact. Health Net Access recommends five days advance notice to schedule in-person interpreters.

These services feature the following:

- Qualified interpreters training on health care terminology and a wide range of interpreting protocols and ethics.
- Support to address common communication challenges across cultures.
- Telephone interpreters in more than 150 languages.
- Oral translations of member materials in more than 150 languages.

Telephone interpreters are available at the time of the appointment without prior arrangement. Allow adequate time before the appointment to get the telephone interpreter on the line.

Sign language interpreter services may be available when requested a minimum of 5 business days in advance of the appointment.

Providers who have questions or need interpreter services may contact the Provider Services Center at 1-888-788-4408, 24 hours a day, seven days a week. In-person interpreters are available Monday through Friday, 7:00 a.m. to 6:00 p.m. When calling, providers must have available the member's name, Health Net Access identification (ID) number, and appointment date and time, if necessary.

A non-English language identification poster is available on the provider website at provider.healthnet.com; select *Provider Library > Forms > Interpreter Services Poster* to print and post it in providers' offices. You may also contact the Cultural & Linguistics (C&L) Services Department for a hard copy of the non-English interpreter poster; for ordering information, see the Additional Information section below. Providers are not required to post this information; however, using this tool makes it easier for providers to identify the specific language needs of the patients who come into their office.

CULTURAL AND LINGUISTIC APPROPRIATENESS

Health Net Access provides the following to comply with mandated cultural and linguistic appropriateness standards:

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- Oral language services that include answering questions and providing assistance in more than 150 non-English languages.
- Upon request, Spanish translation of vital documents that provide information about eligibility and how to participate in the plan.
- A statement indicating how to access language services in the most common non-English languages spoken in Arizona.

PROVIDER RESPONSIBILITIES

Participating providers may use Health Net Access interpreter services to provide interpreters to members who require or request them. Participating providers must ensure that language services meet the established requirements as follows:

- Ensure that interpreters are available at the time of the appointment.
- Ensure that LEP members are not subject to unreasonable delays in the delivery of services including access to providers after hours.
- Do not require or encourage members to use family members or friends as interpreters. Health Net Access strongly discourages the use of minors as interpreters, unless used in an emergency situation.
- Provide interpreter services at no cost to members.
- Extend the same participation opportunities in programs and activities to all members regardless of their language preferences.
- Provide services to LEP members that are as effective as those provided to others.
- Record the language needs of each member, as well as the member's request or refusal of interpreter services, in his or her medical record.
- Advise members that they may file grievances with Health Net Access if their language needs are not met.

PROVIDERS DELEGATED FOR UTILIZATION MANAGEMENT ONLY

In addition to the above, providers delegated for utilization management (UM) must comply with the following:

- Translation services – Upon request, provide Health Net Access with the documents sent to members in a timely manner. If a Health Net Access member requests translation of an English document that was produced by an ancillary provider on Health Net Access' behalf, the provider must refer the member to the Health Net Access Customer Contact Center (CCC) telephone number listed on the member's ID card. When the Health Net Access CCC receives the member's request, Health Net Access contacts the provider requesting a copy of the specific English document for translation. The provider must submit the document within 48 hours of the Health Net Access request.
- Notice of Language Assistance (NOLA) – Include a Health Net Access-specific NOLA, which advises members that they can receive support in their preferred language, with vital documents distributed to Health Net Access members (for example, UM denial and delay notices, and claims notices that require member action). A sample notice is available in the provider operations manuals on the Health Net provider website at provider.healthnet.com. From the Provider Library*,* choose the appropriate audience and product line, and select *Forms > Notice on the Availability of Language Assistance.*

CULTURAL COMPETENCY TRAINING

All Health Net Access participating providers are required to take cultural competency training. Cultural competency training may be met through various programs; however, Health Net Access recommends the Office of Minority Health (OMH) modules. The United States Department of Health and Human Services' Office of Minority Health (OMH) offers a computer-based training (CBT) program, *A Physician's Practical Guide to Culturally Competent Care,* on cultural competency for health care providers*.* The cultural competency curriculum modules (CCCMs) are available to physicians, physician assistants (PAs) and nurse practitioners (NPs), and are self-paced. They were developed to furnish providers with competencies that enable them to better treat an increasingly diverse population. This no-cost educational program is available to providers through the OMH Think Cultural Health website at https://cccm.thinkculturalhealth.hhs.gov. Health Net Access does not sponsor or maintain the OMH CBT or website.

Cultural competency resources are available for use in providers' offices through the provider operations manuals on the provider website at provider.healthnet.com, under *Working with Health Net > Contractual > Policy Library > Provider Library > Operations Manual > Quality Improvement > Industry Collaboration Effort (ICE): Provider Tools to Care for Diverse Populations*. Health Net's C&L Services Department can create customized cultural competency training upon request.

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

Providers who would like information about cross-cultural communication, health literacy or accessing interpreter services may contact Health Net's C&L Services Department by email at Cultural.and.Linguistic.Services@healthnet.com or by telephone at 1-800-977-6750. For all other questions, contact the Health Net Access Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at 1-888-788-4408.

PROVIDER*Update*

NEWS & ANNOUNCEMENTS | JULY 15, 2016 | UPDATE 16-436 | 1 PAGE

Health Net Access™

Arizona KidsCare Coverage

In accordance with Senate Bill (SB) 1475, KidsCare coverage in Arizona is restored for children ages 18 or younger in households that are between 133 percent and 300 percent of the federal poverty level (FPL). KidsCare is Arizona's version of the federal Children's Health Insurance Program (CHIP). Enrollment applications for KidsCare coverage are accepted beginning July 26, 2016, for coverage effective September 1, 2016.

INCOME ELIGIBILITY

In order to qualify for KidsCare coverage, annual household incomes must be as follows:

Household Size*	Maximum Income Level (per year)	Household Size*	Maximum Income Level (per year)
1	$23,760	4	$48,600
2	$32,040	5	$56,880
3	$40,320	6	$65,160

* www.azahcccs.gov/Members/GetCovered/Categories/KidsCare.html.

APPLICATION PROCESS

The KidsCare enrollment application and instructions are available online at www.azahcccs.gov/Members/GetCovered/apply.html or patients may apply directly online at www.healthearizona.org/app/Default.aspx.

For more information, visit www.azahcccs.gov/Members/GetCovered/Categories/KidsCare.html.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

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PROVIDER*Update*

CONTRACTUAL | JULY 5, 2016 | UPDATE 16-401 | 1 PAGE

Health Net Access™

Provider Demographic Data Verification Reminder

To ensure Health Net Access, Inc. members have access to accurate information when selecting providers, providers are required to provide advance notification to Health Net Access, their medical groups or independent practice associations (IPAs) when they have changes to their demographic information. On a monthly basis, providers should validate that their demographic information is reflected correctly on the provider website at www.healthnet.com under ProviderSearch.

DEMOGRAPHIC INFORMATION

Providers' demographic data 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 Access must notify Health Net Access of changes by completing the online form or by reaching out to their provider network administrator (PNA). The online form is available on the provider website at provider.healthnet.com under *My Account > Profile > Update Provider Information.* Providers must have the *Update Provider Information* privileges to update and submit changes online.

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 Access. Medical groups and IPAs must have policies in place that establish and implement processes to collect, maintain and submit their provider demographic changes to Health Net Access on a real-time basis. Real-time is within 30 days, as recently defined by the Centers for Medicare & Medicaid Services (CMS). Health Net Access conducts random audits of medical groups and IPAs to validate processes and policies to ensure they are maintaining provider demographic information on a regular basis.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

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PROVIDER*Update*

CONTRACTUAL | JULY 1, 2016 | UPDATE 16-425 | 3 PAGES

Health Net Access™

New Health Net Access Prior Authorization Request Forms

Effective August 1, 2016, Health Net Access, Inc. providers must use the new prior authorization request forms to request standard or expedited authorization for medical services, procedures or equipment that require prior authorization. Providers must complete and submit the Inpatient Prior Authorization Fax Form or Outpatient Prior Authorization Fax Form for prior authorization requests to ensure timely prior authorization processing.

Providers must adhere to the following Health Net Access procedures for requesting prior authorization:

- The requesting physician's signature must be included on expedited requests.
- Forms must be completed in their entirety.
- Supporting documentation must be submitted along with the request and cannot be older than one year.
- A separate form must be used for each prior authorization request.

The Inpatient Prior Authorization Fax Form and Outpatient Prior Authorization Fax Form are attached for reference and also available on the provider website at www.healthnetaccess.com.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

Enroll for Electronic Payment and Remittance

Enroll for electronic remittance advice (ERA) and electronic funds transfer (EFT) to reduce administrative work and check-processing expenses, and expedite payment and remittance receipt. ERA requires you to also enroll with your clearinghouse. Enrollment forms for ERA and EFT are available online at provider.healthnet.com under *Working with Health Net > EDI > Transfer Funds Electronically*.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

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fax 1-800-937-6086

Health Net Access™

INPATIENT Prior Authorization Fax Form

Fax to: 855-764-8513

☐ Standard Request - Determination within 14 calendar days of receiving all necessary information.

☐ Expedited Request -I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

X _____ URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

* *INDICATES REQUIRED FIELD*

MEMBER INFORMATION

Member ID *

Last Name, First

Date of Birth * (MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting NPI *

Requesting TIN *

Requesting Provider Contact Name

Requesting Provider Name

Phone

Fax

SERVICING PROVIDER / FACILITY INFORMATION

☐ *Same as Requesting Provider*

Servicing NPI *

Servicing TIN *

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

Primary Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Start Date *OR* Admission Date * (MMDDYYYY)

Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity (MMDDYYYY)

Diagnosis Code * (ICD-10)

Additional Diagnosis Code (ICD-10)

INPATIENT SERVICE TYPE * *(Enter the Service type number in the boxes)*

141	Premature/False Labor
300	Neonate
121	Long Term Acute Care
492	Sub Acute
402	Skilled Nursing Facility
970	Medical
411	Surgical
209	Transplant Surgery

Delivery

779	C-Section
720	Vaginal Delivery

Inpatient Rehab

220	Comprehensive Inpatient Rehab Facility
479	Inpatient Hospital

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered benefit and medically necessary with prior authorization as per Ambetter policy and procedures.

Health Net Access™

OUTPATIENT
PRIOR AUTHORIZATION FAX FORM

Complete and Fax to: 855-764-8513

☐ Request for additional units. Existing Authorization _____ Units _____

☐ Standard Request - Determination within 14 calendar days of receiving all necessary information

☐ Expedited Request -I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

X _____ URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

*INDICATES REQUIRED FIELD

MEMBER INFORMATION

Member ID/Medicaid ID *

Last Name, First

Date of Birth * (MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting NPI *

Requesting TIN*

Requesting Provider Contact Name

Requesting Provider Name

Phone

Fax

SERVICING PROVIDER / FACILITY INFORMATION

↳ ☐ Same as Requesting Provider

Servicing NPI *

Servicing TIN *

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

Primary Procedure Code * (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Start Date OR Admission Date* (MMDDYYYY)

Diagnosis Code* (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

End Date OR Discharge Date (MMDDYYYY)

Total Units/Visits/Days

OUTPATIENT SERVICE TYPE *

(Enter the Service type number in the boxes) _____

412 Auditory Services
422 Biopharmacy

DME

417 Rental
120 Purchase $ (Purchase Price)

299 Drug Testing
922 Experimental & Investigational Services
709 Genetic Testing
799 Genetic Counseling

249 Home Health
927 Outpatient Hospice
290 Hyperbaric Oxygen Therapy
410 Observation
792 Vendor

Nutritional Supplements and/or services

407 Enteral Feedings
441 Parenteral Feedings
360 Modified Solid Food Supplements

650 Radiation Therapy
472 Stereotactic Radiosurgery
499 Transplants - Office Visit
109 Transplants - Other Visit
724 Transportation
997 Office Visit/Consult (non par)
365 Office Visit/Vaccines & Administration
370 Office Visit/Dermatology Procedure
375 Office Visit/ Dental

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COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Rev. 05 19 2016
XZ-PAF-1126

PROVIDER*Update*

CONTRACTUAL | JUNE 10, 2016 | UPDATE 16-341 | 1 PAGE

Health Net Access™

Correction to Effective Date for Envolve™ Vision Vendor Change

Provider update 16-319, *Prior Authorization Process, Website Re-Registration and Vision Vendor Changes*, distributed June 1, 2016, included an incorrect effective date for the Health Net Access, Inc. vision vendor change. Envolve Benefit Options (Envolve™) will be the vision vendor for Health Net Access, effective July 1, 2016.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

Discover Helpful Tools to Support Your Office

The Provider Library online at provider.healthnet.com allows participating providers to quickly access pertinent information to assist in their everyday interaction with Health Net. The Provider Library includes operations manuals, communications (updates and letters), Online News articles, forms, Health Net contact information, and more.

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PROVIDER*Update*

NEWS & ANNOUNCEMENTS | JUNE 7, 2016 | UPDATE 16-324 | 5 PAGES

Health Net Access™

Measles Prevention in Arizona

The Arizona Department of Health Services (ADHS), Maricopa County Department of Public Health and Pinal County Public Health Services District confirmed 10 cases of measles in Arizona. Additional cases in the community are highly likely.

Health Net Access, Inc. recommends health care providers do the following to prevent additional measles cases:

- Take precautions to ensure patients are not exposed to measles by:
  - Posting the attached four handouts outside of the provider's facility and having surgical masks available.
  - Having patients with febrile rash illness report to a back door or provide the last appointment of the day to prevent exposure to other patients.
  - Having patients suspected of having measles wear surgical masks in common areas when airborne isolation is not available.
- Immediately mask and place patients presenting with a febrile rash illness in airborne isolation, if available, and obtain vaccine and travel history.
- Consider measles a diagnosis for patients with a febrile rash illness and immediately report these cases to the local health department.
- Coordinate with the local health department for specimen collection, transport and testing of suspected measles cases.
- Ensure all staff is fully immunized. Health care workers must receive two doses of the measles, mumps and rubella (MMR) vaccine, regardless of year of birth, unless documentation of previous immunity is provided.

INFORMATION AND RESOURCES

The following resources are available for providers through the ADHS website:

- To report measles cases or for additional information, contact the local county health department listed at www.azdhs.gov/preparedness/epidemiology-disease-control/index.php#resources-county.
- A Measles Surveillance Toolkit for Healthcare Settings is available at www.azdhs.gov/documents/preparedness/epidemiology-disease-control/measles/measles-surveillance-toolkit.pdf.
- For information about confirmed measles cases, visit azdhs.gov/director/public-information-office/index.php#releases-adhs.
- For additional information about measles, refer to www.azdhs.gov/preparedness/epidemiology-disease-control/measles/index.php.

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

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Think it might be Measles?

Measles is in our County!

If you have ANY of these symptoms:
Cough, Runny Nose, Red eyes, or Fever OR RASH!

PUT A MASK ON and tell the receptionist right away.

¿Cree que tiene Sarampión?

¡Tenemos Sarampión en nuestro Condado!

Si usted tiene CUALQUIERA de estos síntomas:

Tos, Nariz congestionada o moquienta, Ojos rojos, o Fiebre O ERUPCIÓN/SARPULLIDO

PÓNGASE UNA MÁSCARA y luego dígale a la recepcionista inmediatamente

ARIZONA DEPARTMENT
OF HEALTH SERVICES

Emergency Room Discharge Instructions for Suspect Measles Patients

- Your illness may be due to measles, a highly contagious disease that can be prevented with vaccine. Please follow the instructions below to avoid giving this disease to other people in your home and in your community.
- Wear a surgical mask until you arrive at home. You may take off the mask inside your home.
- Stay home until you are contacted by your local health department with further instructions. If you do not hear from your local health department within 24 hours, their contact information can be found below:

County	Day Time Hours	After Hours
Apache	928-337-4364	928-337-4321
Cochise	520-432-9400	800-423-7271
Coconino	928-679-7272	928-255-8715
Gila	928-402-8811	928-701-1610
Graham	928-428-1962	928-965-8921
Greenlee	928-865-2601	928-865-4149
La Paz	928-669-1100	928-669-2281
Maricopa	602-506-6767	602-747-7111
Mohave	928-753-0714	928-718-4927
Navajo	928-524-4750	928-241-0960
Pima	520-724-7770	520-743-7987
Pinal	520-866-7325	520-866-6239
Santa Cruz	520-375-7900	877-202-0586
Yavapai	928-771-3134	928-442-5262
Yuma	928-317-4450	928-317-4624

If you are unable to reach the local health department, please call the Arizona Department of Health Services at 602-364-3676 or after hours at 480-303-1191.

- Do not go near pregnant women, people with weakened immune systems, or infants under 1 year of age.
- Make sure that household members are fully immunized against measles.
    - Check immunization records or talk to your doctor.
    - Fully immunized: 2 doses of MMR given 28 days apart.
- Only have contact with people who are fully immunized against measles.
- For more information, please visit the ADHS measles webpage: http://tinyurl.com/azmeasles

Last Modified: 5-28-2016

ARIZONA DEPARTMENT
OF HEALTH SERVICES

Inpatient Discharge Instructions for Suspect Measles Patients

- Your illness may be due to measles, a highly contagious disease that can be prevented with vaccine. Please follow the instructions below to avoid giving this disease to other people in your home and in your community.

- Wear a surgical mask until you arrive at home. You may take off the mask inside your home.

- Stay home until you are contacted by your local health department with further instructions. If you do not hear from your local health department within 24 hours, their contact information can be found below:

County	Day Time Hours	After Hours
Apache	928-337-4364	928-337-4321
Cochise	520-432-9400	800-423-7271
Coconino	928-679-7272	928-255-8715
Gila	928-402-8811	928-701-1610
Graham	928-428-1962	928-965-8921
Greenlee	928-865-2601	928-865-4149
La Paz	928-669-1100	928-669-2281
Maricopa	602-506-6767	602-747-7111
Mohave	928-753-0714	928-718-4927
Navajo	928-524-4750	928-241-0960
Pima	520-724-7770	520-743-7987
Pinal	520-866-7325	520-866-6239
Santa Cruz	520-375-7900	877-202-0586
Yavapai	928-771-3134	928-442-5262
Yuma	928-317-4450	928-317-4624

If you are unable to reach the local health department, please call the Arizona Department of Health Services at 602-364-3676 or after hours at 480-303-1191.

- Do not go near pregnant women, people with weakened immune systems, or infants under 1 year of age.

- Make sure that household members are fully immunized against measles.
    - Check immunization records or talk to your doctor.
    - Fully immunized: 2 doses of MMR given 28 days apart.

- Only have contact with people who are fully immunized against measles.

- For more information, please visit the ADHS measles webpage: http://tinyurl.com/azmeasles

Last Modified: 5-28-2016

PROVIDER*Update*

CONTRACTUAL | JUNE 1, 2016 | UPDATE 16-320 | 3 PAGES

Health Net Access™

New Claims Processes for Health Net Access Transition

On March 24, 2016, Centene acquired Health Net, including the Health Net Access (HNA) plan. Centene and HNA remain committed to quality health care and view this change as an opportunity to pursue higher levels of quality and access to health care services for our members and excellent customer support for our providers. This following is a list of the key changes that will impact all HNA network providers.

Please keep this document as a reference if you have any issues or concerns. Thank you for your continued partnership in serving the Arizona State Medicaid population in Maricopa County.

CLAIMS PROCESSING CHANGES

You will receive payments from HNA for dates of service (DOS) prior to June 30, 2016. You will receive payments from Centene for DOS July 1, 2016, and beyond. HNA is anticipating an 18-month period of time where you may receive payments from both entities depending on DOS. The following are updates related to claims processing.

Optical Character Recognition (OCR) of Claims Forms

HNA has been working to implement new technology in our claims organization to improve the Optical Character Recognition (OCR) of claims forms, to give better service, improve quality, and reduce costs. As a result, HNA will be no longer accepting handwritten red forms or black or copied claims forms.

Effective July 1, 2016, the only acceptable claim forms will be those printed in Flint OCR Red, J6983, (or exact match) ink. 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, will no longer be accepted by HNA effective July 1, 2016.

You can find Medicare CMS-1500 and CMS-1450 completion and coding instructions, as well as the print specifications in Chapter 26 of the Medicare Claims Processing Manual (Pub.100-04). Blank copies of the form may also be available through office supply stores in your geographic area.

Lastly, there will be fewer duplicative claims and this is a step forward in improving quality as well as reducing the potential for fraud, waste, and abuse.

As a reminder, providers have available the use of HNA's secure online portal for electronic claims submissions.

For questions or concerns, contact 1-888-788-4408.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- Physicians
- Medical Groups/IPAs
- Hospitals
- Ancillary Providers

PROVIDER SERVICES

az_internetproviderinquiries@healthnet.com
1-888-788-4408
www.healthnet.com

PROVIDER DISPUTES

Health Net Access Provider Disputes
1230 W Washington Street, Ste. 401
Tempe, AZ 85281

STATE FAIR HEARINGS

Health Net Access Provider State Fair Hearings
1230 W Washington Street, Ste. 401
Tempe, AZ 85281

NATIONAL PROVIDER COMMUNICATIONS

provider.communications@healthnet.com
fax 1-800-937-6086

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DRG Billing Changes

As a reminder, effective October 1, 2014, Arizona Health Care Cost Containment System (AHCCCS) began to determine Medicaid reimbursement for most acute care hospital inpatient services for the majority of Arizona hospitals, and out-of-state hospitals, using a Diagnosis Related Group (DRG) payment methodology.

Effective July 1, 2016, HNA will conduct check-run sample reviews for providers with inpatient claims using targeted diagnosis codes to ensure that claims processes related to DRG are being followed. If necessary, provider education will be conducted.

For questions or concerns**,** contact 1-888-788-4408.

NEW CLAIMS EDITS

Effective July 1, 2016, HNA will add additional claims edits in order to reduce the current HNA encounters issues.

The following is a current list of the new encounter-related claims edits that will be implemented:

Edit	Description
7S	DENY: PROCEDURE NOT COVERED ON DATE BY AHCCCS
Ic	DENY: INVALID REV CODE BILL TYPE COMBO
ZH	DENY: HCPCS CPT IS NOT COMPATIBLE WITH REVENUE CODE BILLED
7X	DENY: INVALID PROCEDURE CODE MODIFIER COMBINATION
M8	DENY: VALIDATE MEMBER AGE FOR SERVICE
V7	DENY: VALIDATE MEMBER GENDER FOR SERVICE
N1	DENY: PROVIDER NOT ALLOWED TO PERFORM SERVICE
Ma	DENY: MAX UNITS EXCEEDED
BG	DENY: TYPE OF BILL MISSING OR INCORRECT ON CLAIM, PLEASE RE-SUBMIT
8F	DENY: ADMISSION SOURCE MISSING OR INVALID
IG	DENY: INVALID OR MISSING DISCHARGE STATUS, PLEASE RE-SUBMIT
4b	DENY: DIAGNOSIS CODE 1 MISSING OR INVALID
4c	DENY: DIAGNOSIS CODE 2 MISSING OR INVALID
4d	DENY: DIAGNOSIS CODE 3 MISSING OR INVALID
4e	DENY: DIAGNOSIS CODE 4 MISSING OR INVALID
6a	DENY: ICD9/10 PROC CODE 1 VALUE OR DATE IS MISSING/INVALID
7V	DENY-N153: PROV TYPE IS INVALID FOR THIS PROCEDURE
Sw	DENY: CATEGORY OF SVC INVALID FOR THIS PROCEDURE
7U	DENY-N150: INVALID PLACE OF SVC FOR THIS PROC CODE
8F	DENY: ADMISSION SOURCE MISSING OR INVALID
Md	DENY: MEDICARE ONLY PROCEDURE CODE. PROC NOT COVERED
6C	DENY: INVALID REV CODE
7X	DENY: INVALID PROCEDURE CODE MODIFIER COMBINATION
BG	DENY: TYPE OF BILL MISSING OR INCORRECT ON CLAIM, PLEASE RE-SUBMIT
I9	DENY: DIAGNOSIS IS MISSING, INVALID OR DELETED ICD9 CODE
Ad	DENY: INVALID ADMITTING DIAG CODE
6N	DENY: NDC NUMBER MISSING OR INVALID

N6	DENY: NDC UNIT OF MEASURE QUALIFIER OR QUANTITY MISSING OR INVALID
8K	DENY: ECI DIAGNOSIS 1 INVALID OR REQUIRES ADDITIONAL DIGIT
8N	DENY: ECI DIAGNOSIS 2 INVALID OR REQUIRES ADDITIONAL DIGIT
8O	DENY: ECI DIAGNOSIS 3 INVALID OR REQUIRES ADDITIONAL DIGIT
8P	DENY: ECI DIAGNOSIS 4 INVALID OR REQUIRES ADDITIONAL DIGIT
8Q	DENY: ECI DIAGNOSIS 5 INVALID OR REQUIRES ADDITIONAL DIGIT
8S	DENY: ECI DIAGNOSIS 6 INVALID OR REQUIRES ADDITIONAL DIGIT
8X	DENY: ECI DIAGNOSIS 7 INVALID OR REQUIRES ADDITIONAL DIGIT
8U	DENY: ECI DIAGNOSIS 8 INVALID OR REQUIRES ADDITIONAL DIGIT
8V	DENY: ECI DIAGNOSIS 9 INVALID OR REQUIRES ADDITIONAL DIGIT
8W	DENY: ECI DIAGNOSIS 10 INVALID OR REQUIRES ADDITIONAL DIGIT
8G	DENY: ECI DIAGNOSIS 11 INVALID OR REQUIRES ADDITIONAL DIGIT
8H	DENY: ECI DIAGNOSIS 12 INVALID OR REQUIRES ADDITIONAL DIGIT
9R	DENY: PATIENT REASON DIAGNOSIS 1 INVALID OR REQ ADDL DIGIT
9S	DENY: PATIENT REASON DIAGNOSIS 2 INVALID OR REQ ADDL DIGIT
9Q	DENY: PATIENT REASON DIAGNOSIS 3 INVALID OR REQ ADDL DIGIT
8j	DENY: ADMIT TYPE OR SOURCE OR DISCH STATUS MISSING/INVALID
EG	DENY: ADMIT DATE = MEMBER DOB
cH	DENY: ADMISSION TYPE IS MISSING OR INVALID
KZ	DENY: INVALID PLACE OF SERVICE, PLEASE CONSULT THE PROV MANUAL
IV	DENY: INVALID DELETED MISSING CPT CODE
IG	DENY: INVALID OR MISSING DISCHARGE STATUS, PLEASE RE-SUBMIT
Ip	DENY: INAPPROPRIATE PRIMARY ADMITTING DIAG CODE
RJ	DENY: REVENUE CODES NOT BILLED ON THE UB92, PLEASE RE-SUBMIT
8b	DENY: DISCHARGE HOUR INVALID WITH DISCHARGE STATUS 30
2H	DENY: ADMIT TYPE OR SOURCE MISSING OR INVALID

Effective July 1, 2016, claims that do not meet the claim edit requirements will be considered non-compliant and HNA will no longer accept non-compliant claims.

Providers will maintain all applicable claim dispute rights as outlined in the Health Net Access provider operations manual at www.healthnetaccess.com.

For questions or concerns, contact 1-888-788-4408.

PROVIDER*Update*

CONTRACTUAL | JUNE 1, 2016 | UPDATE 16-319 | 8 PAGES

Health Net Access™

Prior Authorization Process, Website Re-Registration and Vision Vendor Changes

On March 24, 2016, Centene acquired Health Net, including the Health Net Access (HNA) plan. Centene and HNA remain committed to quality health care and view this change as an opportunity to pursue higher levels of quality and access to health care services for our members and excellent customer support for our providers. This following is a list of the key changes that will impact all HNA network providers.

Please keep this document as a reference if you have any issues or concerns. Thank you for your continued partnership in serving the Arizona State Medicaid population in Maricopa County.

PRIOR AUTHORIZATION REQUIREMENTS

Online Authorization Tool

Effective July 1, 2016, HNA providers will be able to utilize an online authorization tool to help determine whether services require plan prior authorization. To access the online tool, visit www.healthnetaccess.com.

All attempts are made to provide the most current information on the Pre-Auth Needed Tool at www.healthnetaccess.com; however, this does **not** guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding, and billing practices. For specific details, please refer to the Health Net Access provider operations manual. If you are uncertain whether prior authorization is needed, please submit a request for an accurate response.

For questions or concerns, contact 1-888-788-4408.

Prior Authorization Changes

Effective July 1, 2016, the following modifications have been made to the HNA prior authorization requirements. Information regarding Health Net Access prior authorization policies and procedures is also available in the Health Net Access provider operations manuals. The Health Net Access Prior Authorization List is attached for reference.

Additions

- Chondrocyte implants.
- Outpatient pharmaceuticals: Cosentyx®, H.P. Acthar® Gel and Lemtrada®.
- Outpatient physical, occupational and speech therapy (rehabilitative and habilitative services).

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- Physicians
- Medical Groups/IPAs
- Hospitals
- Ancillary Providers

PROVIDER SERVICES

az_internetproviderinquiries@healthnet.com
1-888-788-4408
www.healthnet.com

PROVIDER DISPUTES

Health Net Access Provider Disputes
1230 W Washington Street, Ste. 401
Tempe, AZ 85281

STATE FAIR HEARINGS

Health Net Access Provider State Fair Hearings
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Tempe, AZ 85281

NATIONAL PROVIDER COMMUNICATIONS

provider.communications@healthnet.com
fax 1-800-937-6086

Changes

- A*mbulance* - prior authorization required for non-emergency fixed wing air transportation only (previously listed as all non-emergency air or ground transportation).
- *Back surgery* – changed to *back/spinal surgery.*
- *Custom orthotics* – no longer limited to members under age 21.
- *Dental* – added clarification that dental procedure covered by medical benefit requires prior authorization. Dental Benefit Providers provides authorization for all other dental services.
- *Dermatology* – removed "in-office procedures" and added clarification that procedure includes, but is not limited to chemical exfoliation and electrolysis, dermabrasion/chemical peel, laser treatment, and skin injections and implants.
- *Durable medical equipment (DME)* – removed "applies to items exceeding $2,500 in billed charges." Providers should refer to the online prior authorization tool, as described in the previous section, for guidance on DME authorization requirements.
- *Enteral/parenteral services and supplies* – changed to *enteral/parenteral/medical foods services and supplies.*
- *Genetic testing* – removed "covered only to differentiate between treatment options."
- *Home health services* – all home health services require prior authorization.
- O*bservation services* - notification required only if less than 24 hours. If more than 24 hours, authorization is required.
- Outpatient pharmaceuticals – changed *intravenous immunoglobulin (IVIG)* to *immune globulin*. Examples include IVIG, Hizentra® and HYQVIA.
- *Prosthetics* – removed "applies to items exceeding $2,500 in billed charges." Providers should refer to the online prior authorization tool, as described in the previous section, for guidance on prosthetic authorization requirements.

Removals

- Cardiac and pulmonary rehabilitation.
- Circumcision.
- Incontinence briefs.
- LifeVest®.
- Outpatient pharmaceuticals: *Ceredase®.*

As a reminder, the following changes to prior authorization requirements for maternity services are effective July 1, 2016, as communicated in provider update 16-238, *Maternity Prior Authorization Changes*, distributed on April 19, 2016:

- Prior authorization is required at the time of the member's first prenatal visit.
- 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. The Health Net Access Request for Prior Authorization form is available in the Forms section of the Health Net Access website at www.healthnetaccess.com.

WEBSITE AND PROVIDER WEB PORTAL CHANGES

Effective July 1, 2016, the HNA website has a new look, but you can continue to access your favorite documents as well as gain access to additional resource information, including:

- Non-Secured Resources
  - Provider Manual
  - Billing Guidelines

- Satisfaction Survey Results

- Secured Resources (Requires Secure Account)
  - Member Eligibility
  - Research Claims
  - Prior Authorization Status

New Process Requirements

HNA providers will access the secure web portal utilizing the same link at www.healthnetaccess.com. Starting July 1, 2016, all HNA providers need to re-register for access to the online secure portal.

To re-register for web portal access visit www.healthnetaccess.com

For questions or concerns, contact 1-888-788-4408.

ENVOLVE VISION VENDOR

Effective June 1, 2016, Envolve Benefit Options (Envolve) is the HNA vision vendor. Envolve provides HNA members with routine eye care needs. There is no change in member vision benefits.

Members or their representatives can contact HNA's member services department at 1-888-788-4408 for assistance with benefits or locating a vision provider.

If you would like to contract with Envolve, or if you have questions, contact the Envolve Network Management Department at 1-800-531-2818 or mail at networkmanagement@opticare.net. You can also visit the Envolve website at www.opticare.com/logon.

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)	

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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

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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

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.

PROVIDER*Update*

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Health Net Access™

Health Net Adds New Specialty Pharmacy AcariaHealth™

Health Net Access, Inc. is collaborating with AcariaHealth™ to provide specialty prescription medications for Medicaid members in Arizona.

Effective June 1 2016, AcariaHealth is Health Net Access's new preferred full service specialty pharmacy for most specialty medication therapies. AcariaHealth provides high-quality medications and services for chronic and complex conditions, such as hepatitis C, hemophilia, oncology, multiple sclerosis, and other conditions that require special handling or training.

Using the services of a specialty pharmacy helps to ensure continued quality service for these sensitive members. Additionally, it makes it easy and convenient for members to obtain all specialty medications and services from one location whenever possible.

AcariaHealth may reach out to providers who have patients currently taking specialty medications to request information, new prescriptions, and to introduce providers to AcariaHealth's services. Participating providers are encouraged to support this transition, to avoid disruption in Health Net Access members' care. Providers may continue to send prior authorization requests to Health Net Access.

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have any questions regarding this notice please contact your Provider Relations representative or contact the Health Net Access Provider Services Center at 1-888-788-4408.

Online News for Providers

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THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- ● Physicians
- ● Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

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1-888-788-4408
www.healthnet.com

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fax 1-800-937-6086

PROVIDER*Update*

CONTRACTUAL | APRIL 21, 2016 | UPDATE 16-228 | 3 PAGES

Health Net Access™

Medical Policies – 1st Quarter 2016

This provider update includes a listing of updated preventive health guidelines, MHN updates, and new and updated Health Net Access, Inc. (Health Net) medical policies approved by the Health Net National Medical Advisory Council (MAC) in the first quarter of 2016. For a complete description of new and updated medical policies, visit the Health Net provider website at provider.healthnet.com and select *Working with Health Net > Medical Policies*.

PURPOSE OF HEALTH NET MEDICAL POLICIES

Medical policies provide guidelines for determining medical necessity for specific procedures, equipment and services. All services must be medically necessary to be eligible for benefit coverage, unless otherwise defined in the member's benefits contract. The determination for coverage is also based on all of the terms of the individual member's benefits contract, including, but not limited to, eligibility at the time of service and description of covered benefits, limitations and exclusions. In some cases, legal or regulatory mandate requirements may be applicable and may prevail over medical policy. To the extent there are any conflicts between medical policy guidelines and applicable benefit contract language, the benefit contract language prevails. Medical policy is not intended to override the *Member Handbook* or the health insurance policy that defines the member's benefits, nor is it intended to provide medical advice or dictate to providers how to practice. If required, prior authorization must be obtained before services are rendered.

Preventive Health Guidelines Updates

Guideline	Source of Recommendations
2016 ADULT FEMALE AND ADULT MALE PREVENTIVE HEALTH GUIDELINES	Various sources, including United States Preventive Services Task Force (USPSTF), physician academies and societies, National Comprehensive Cancer Network (NCCN), American Congress of Obstetricians and Gynecologists (ACOG), American Cancer Society, Centers for Disease Control and Prevention (CDC)
2016 ADULT IMMUNIZATION SCHEDULE	CDC Advisory Committee on Immunization Practices (ACIP)
2016 CHILDHOOD AND ADOLESCENT IMMUNIZATION SCHEDULE	CDC ACIP
2016 MATERNITY HEALTH GUIDELINES	ACOG

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Preventive Health Guidelines Updates, continued

Guideline	Source of Recommendations
2016 MEDICARE ADVANTAGE PREVENTIVE HEALTH GUIDELINES	Centers for Medicare & Medicaid Services (CMS)
2016 PEDIATRIC PREVENTIVE HEALTH GUIDELINES	American Academy of Pediatrics (AAP) Bright Futures

New Policy

Medical Policy	Policy Statement
TESTING FOR DRUGS OF ABUSE (DOA)	Health Net considers quantitative drug testing for drugs of abuse (DOA) as medically necessary for confirmatory testing for a specific drug when members meet the criteria in A or B, as follows: A. Member has a documented history or suspicion of illicit or prescription drug use or noncompliance, or a high probability of non-adherence to a prescribed medication regimen documented in the medical record; *and all of the following:* • A qualitative drug test has been previously performed; *and* • The findings from that qualitative test (either positive or negative) are either: - Inconsistent with the expected results as suggested by the member's medical history, clinical presentation, and/or member's own statement after a detailed discussion about his or her recent medication and drug use; - The qualitative test yields results consistent with the clinical scenario, but drug class-specific assays are needed to identify the precise drug(s) that resulted in the positive test result, without which, treatment may be delayed or incorrect; - Resolving the inconsistency is essential to the ongoing care of the member; and - The requested quantitative test is only for the specific drug for which qualitative analysis has yielded unexpected results. B. The request is for a serum therapeutic drug level in relation to the medical treatment of a disease or condition, such as phenobarbital level in the treatment of seizures. Refer to the policy for more details about non-coverage, authorization/ documentation requirements and frequency testing.

MHN Updates

Policy	Change
BUPRENORPHINE TREATMENT	No major changes; however, additional information related to the mortality and morbidity of the current opioid epidemic, note about monotherapy in pregnancy, description of the various formulations, such as Zubsolv® sublingual tablet and Bunavail® buccal film, and updated references were added

MHN Updates, continued

Policy	Change
MAJOR DEPRESSION CLINICAL PRACTICE GUIDELINE	Updated references – no major changes
PHOTOTHERAPY FOR SEASONAL AFFECTIVE DISORDER	No changes other than formatting and adding current references
SUBSTANCE ABUSE DISORDER CLINICAL PRACTICE GUIDELINE	Updated references – no major changes

Updated Policies

Medical Policy	Change
COLONOSCOPY	Added additional criteria under sections, “Low-risk patients with no family history of colorectal cancer,” and “High-risk patients with a personal history of colorectal cancer,” based on 2015/2016 NCCN recommendations. Minor changes throughout policy statement, also based on NCCN recommendations. Codes have been updated
COMPARATIVE GENOMIC HYBRIDIZATION (CGH)	Based on NCCN guidelines for melanoma (2.2016), added CGH as medically necessary for evaluating histologically equivocal Spitzoid melanocytic neoplasms (Spitz nevus and atypical Spitz tumors)
GENETIC TESTING FOR BRCA1 AND BRCA2	Revised policy statement according to NCCN (version 1.2016) updated guidelines on Genetic/Familial High Risk-Assessment for Breast and Ovarian cancer, for BRCA testing
MAMMAPRINT®, PROSIGNA® AND OTHER GENE EXPRESSION TESTS FOR BREAST CANCER	Added OncoVue® for breast cancer risk assessment as not medically necessary due to a paucity of peer-reviewed studies to support this assay
TERBUTALINE PUMP	Revised policy statement to consider the use of a portable external pump for temporary administration of outpatient ambulatory continuous and/or intermittent subcutaneous terbutaline for the prevention or suppression of premature labor as not medically necessary
VAGUS NERVE STIMULATION (VNS)	Added AspireSR® VNS system as investigational due to insufficient evidence-based literature regarding the AspireSR Model 106 Added transcutaneous VNS (tVNS) for mild to moderate depression (MDD) as investigational since the studies are small with short-term follow up Removed Neurocybernetic Prosthesis (NCP) System as the only U.S. Food and Drug Administration (FDA)-approved VNS device
VARICOSE VEIN TREATMENT	Added Varithena®, a proprietary microfoam sclerosant dispersed from a canister, as investigational based on the paucity of published evidence on the efficacy, and the available studies are short in duration and lack comparisons with other minimally invasive therapies for varicose veins Added VenaSeal™ closure system, which uses cyanoacrylate embolization (CAE), a form of vascular embolization, as investigational, due to a paucity of peer-reviewed studies to support it

PROVIDER*Update*

CONTRACTUAL | APRIL 19, 2016 | UPDATE 16-238 | 2 PAGES

Health Net Access™

Maternity Prior Authorization Changes

The Arizona Health Care Cost Containment System (AHCCCS) requires health plans to reach out and educate pregnant Health Net Access, Inc. members regarding the importance of early prenatal care and care throughout the member's entire pregnancy. To comply with this requirement, Health Net Access is reaching out to pregnant members every month during pregnancy and after delivery to complete a postpartum assessment, which includes evaluating for postpartum depression.

PRIOR AUTHORIZATION CHANGES

To help identify Health Net Access members who are pregnant and appropriately reach out to them throughout their pregnancy, the prior authorization requirements for maternity services are changing, effective July 1, 2016, as follows:

- Prior authorization is required at the time of the member's first prenatal visit.
- 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. The Health Net Access Request for Prior Authorization form is available in the *Forms* section of the Health Net Access website at www.healthnetaccess.com.

Authorized maternity services include all maternity services that do not require a separate authorization.

The Health Net Access prior authorization requirements have been modified to reflect the changes made to maternity services. Providers can refer to the prior authorization requirements on provider.healthnet.com pre-log in under *Working with Health Net > Policies for Non-Contracting Providers > Services Requiring Prior Authorization* (under Additional Resources). The prior authorization requirements are also available after logging in under *Working with Health Net > Contractual > Services Requiring Prior Authorization* or in the Health Net Provider Library under *Operations Manuals > Prior Authorization*. Information regarding Health Net Access prior authorization policies and procedures is also available in the operations manuals.

CLAIMS SUBMISSION AND REIMBURSEMENT

Providers are required to follow standard AHCCCS requirements for claims submission for maternity services. All antepartum and postpartum service dates must be reported individually.

The total reimbursement for maternity services must include a minimum of five antepartum visits during an eligible period of coverage. Reimbursement is provided at the time of delivery and includes all antepartum and postpartum evaluation and management visits.

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Additional information on claims and provider reimbursement is available in the Health Net Access provider operations manuals in the Provider Library.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at www.healthnetaccess.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

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PROVIDER*Update*

CONTRACTUAL | APRIL 13, 2016 | UPDATE 16-218 | 2 PAGES

Health Net Access™

Addresses and Enrollment Information for ERA and EFT

This communication provides information about submitting Health Net Access, Inc. provider claim disputes and provider state fair hearing requests. It also covers provider enrollment information for electronic remittance advice (ERA) and electronic funds transfer (EFT).

ADDRESSES FOR SUBMITTING CLAIM DISPUTES AND STATE FAIR HEARING REQUESTS

Providers should send any claim disputes or state fair hearing requests to the following addresses:

Provider Claim Dispute Requests

Health Net Access Provider Disputes
1230 West Washington Street, Ste. 401
Tempe, AZ 85281

Provider State Fair Hearing Requests

Health Net Access State Fair Hearing
1230 West Washington Street, Ste. 401
Tempe, AZ 85281

ERA

ERA provides details on multiple claims and helps improve business office workflow by allowing the adjudicated claim information to be automatically posted to accounts receivable systems. Health Net sends an ERA to any provider who registers with an approved clearinghouse. ERA complies with Health Insurance Portability and Accountability Act (HIPAA) 835 requirements making it consistent with other payers and is acceptable nationwide.

Enrolling for ERA

Providers have the option to submit the enrollment form online or download the form and send it to Health Net via email or fax.

Online enrollment is available on Health Net's provider website at provider.healthnet.com under *Transactions > Claims > ERA – Electronic Remittance Advice Online Enrollment.*

If the provider prefers to email or fax the ERA enrollment form, the form is available on Health Net's provider website at provider.healthnet.com under *Transactions > Claims > ERA – Electronic Remittance Advice Authorization Agreement.* Complete the

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form and submit it to Health Net via email at edi.support@healthnet.com or by secure fax to 1-800-677-4147, Attention: EDI Business. Providers must also enroll with their clearinghouse.

EFT

EFT automates the distribution of funds into accounts using automated clearinghouse processing to reconcile accounts receivable, which provides significant savings in check processing fees. Before EFT, providers were required to open the mail, pull the check, enter the data into their systems, get the checks to the bank, wait for them to clear, reconcile books, and more. EFT is safe, secure, efficient, and less expensive than paper check payments and collections.

Enrolling for EFT

Providers have the option to submit the enrollment form online or download the form and send it to Health Net via email or fax.

Online enrollment is available on Health Net's provider website at provider.healthnet.com under *Transactions* > *Claims* > *EFT – Electronic Funds Transfer Online Enrollment.*

If the provider prefers to email or fax the EFT enrollment form, the form is available on Health Net's provider website at provider.healthnet.com under *Transactions* > *Claims* > *EFT – Electronic Funds Transfer Authorization Agreement.* Complete the form and submit it, along with a voided check, to Health Net via email at edi.support@healthnet.com or by secure fax to 1-800-677-4147, Attention: EDI Business.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

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PROVIDER *Update*

CONTRACTUAL | APRIL 6, 2016 | UPDATE 16-209 | 2 PAGES

Health Net Access™

Copayments and Balance Billing

Members who are enrolled in an Arizona Health Care Cost Containment System (AHCCCS) plan, such as Health Net Access, Inc., are assigned a copayment level for health care services. The copayment level indicates the member's copayment amount or if the member is exempt from copayments. Providers can determine a member's copayment level on the home page of the member's eligibility screen on the AHCCCS website at https://azweb.statemedicaid.us/.

COPAYMENTS

A copayment is a monetary amount that a member may be required to pay directly to a provider at the time a covered service is rendered. AHCCCS has established two types of copayments:

- Mandatory (also known as *hard*) – Providers can deny services to a member who does not pay his or her copayment.
- Optional (also known as *nominal*) – Providers are prohibited from denying services when a member is unable to pay a copayment.

BALANCE BILLING

Balance billing is the practice of a participating provider billing a member for the difference between the contracted amount and billed charges for covered services. When participating providers contract with Health Net Access, they agree to accept the Health Net Access contracted rate as payment in full. Balance billing members for or sending a member to collections for covered services constitutes a breach of contract, as well as a violation of state and federal statutes (ARS 20-1072; 42 USC section 1396a). In some instances, balance billing of members can result in civil penalties (ARS 36-2903.01 (L)). Participating providers may only seek reimbursement from Health Net Access members for the copayments, coinsurance or deductibles for which AHCCCS has deemed them responsible.

GUIDELINES FOR BILLING HEALTH NET ACCESS MEMBERS

Providers can bill a Health Net Access member when the member knowingly receives a non-covered service. The provider must notify the member in advance of the charges and have the member sign a statement agreeing to pay for the services. This document must be retained in the member's medical record.

The Health Net Access member 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 who have other health care coverage, regardless of plan type. Providers must bill Health Net

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fax 1-800-937-6086

Access for these amounts, and Health Net Access will coordinate the member's benefits with the other plan.

ADDITIONAL INFORMATION

The Health Net Access Provider Reference Guide is available on provider.healthnet.com in the Provider Library under *Provider Reference Guides* > *Health Net Access Provider Reference Guide* and on the AHCCCS website at https://azweb.statemedicaid.us/ for additional information.

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

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Health Net Access™

Health Net Access
Provider Forum

Register today! Availability is limited.

Health Net Access, Inc. and the Provider Relations Department invite you to an upcoming provider forum for Health Net Access contracted providers. This is a no-cost training event designed for Health Net Access primary care physicians (PCPs), obstetricians and gynecologists (OB/GYNs), specialists, office staff, and billing teams (two representatives per office).

Date:

Tuesday, April 26, 2016
11:00 a.m. to 1:00 p.m., Mountain time (MT)
Lunch will be provided.

Place:

Wyndham Garden Phoenix Midtown
3600 N. 2nd Ave.
Phoenix, AZ 85013

RSVP:

Monday, April 11, 2016,
via fax or online, to be entered into a raffle for a gift card.

Fax: **(602) 794-1803** or sign up online at **www.SignUp4.net/public/ap.aspx?EID=20161475E**

Presenters include:

- American Cancer Society, co-presenting with the Greater Valley Area Health Education Center (GVAHEC)
- Health Net Access Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/Maternal Child Health Coordinator
- Preventative Health Collaborative
- Roosevelt Early Childhood Family Resource Center
- Maricopa County Women, Infants and Children (WIC)
- Dentsply
- The Arizona Partnership for Immunization and more

If you are unable to attend the training, materials will be available on the Health Net provider website at provider.healthnet.com under *Working with Health Net* > *Regulatory* > *Health Net Access*, or you may request them from the Health Net Quality Improvement Department via email at AHCCCS_Notification@healthnet.com.

Please register online or complete the information below and fax this form as directed above.

Attendee name (please print)	*Physician/Practice name and tax ID*	*Specialty*	*Telephone*
_____	_____	_____	_____
_____	_____	_____	_____

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PROVIDER*Update*

REGULATORY | MARCH 31, 2016 | UPDATE 16-173 | 2 PAGES

Health Net Access™

Fraud, Waste and Abuse Reporting and Training Reminder

This update reminds Health Net Access, Inc. providers of important information about the federal False Claims Act (FCA), instructions on how to report suspected fraud, waste and abuse (FWA), and provider training requirements for Health Net Access.

FEDERAL FALSE CLAIMS ACT

In accordance with the FCA, the following acts are unlawful:

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

The FCA is important because it:

- Outlines the rights of consumers and providers to take action to combat fraud on behalf of the government.
- Expands the scope of fraud beyond those who knowingly intend to commit it.
- Provides protections to those who bring the false claims to light.
- Establishes stringent penalties for those found guilty.

FRAUD, WASTE AND ABUSE

Health care FWA contributes to the rising cost of health insurance, reduces the amount of funds available to pay honest providers, and reduces the available funds used to provide essential medical services for Medicaid patients. Health Net Access investigates allegations of 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, which is 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's Code of Business Conduct and Ethics, or accessing personal information or protected health information (PHI) without authorization.

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OTH006535EH00 (3/16)

REPORTING FRAUD, WASTE, ABUSE, OR VIOLATIONS OF STANDARDS OF CONDUCT

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

To report suspected FWA, contact Health Net Access via mail or telephone as listed below:

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

To report potential or actual noncompliance or ethical concerns, contact Health Net Access via mail or telephone as listed below:

Health Net Access Compliance Officer
Susan Gilkey
Mail Stop: AZ-920-04-07
5255 E. Williams Circle, Ste. 4000
Tucson, AZ 85711
Health Net's Integrity Line: 1-888-866-1366

FWA TRAINING

Arizona Health Care Cost Containment System (AHCCCS) has launched the Health Plan Provider Fraud module through the AHCCCS website at azahcccs.gov/Fraud/CBT/healthplanproviderfraud/healthplanproviderfraudfs.htm. Health Net Access participating providers can use this training module to satisfy the AHCCCS training requirement for educating staff and providers about fraud and abuse.

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CONTRACTUAL | MARCH 29, 2016 | UPDATE 16-155 | 1 PAGE

Health Net Access™

Health Net and Centene Now Combined as One Company

We are pleased to share that as of March 24, 2016, Health Net, Inc. and Centene Corporation have combined as one company. The combination of both companies makes available a leading diversified, multi-state health care organization that provides access to quality, culturally sensitive health care services to more than 10 million members across the country. At this time, there are no changes to the way Health Net Access, Inc. serves you and coordinates care for members. Policies and operational procedures are currently under review and any future changes related to the merger will be communicated to ensure the transition is seamless and efficient to both providers and members.

Please continue following current policies and procedures as outlined in your Health Net *Provider Participation Agreement* and provider operations manuals, such as for eligibility verification, prior authorization and referrals, claims submission, and grievances and appeals. Provider operations manuals are located in the Provider Library on the Health Net provider website at *provider.healthnet.com*.

BENEFITS OF THE MERGER

Our combined company provides new opportunities for innovative health care products and specialty service solutions that focus on all segments, including government-sponsored programs, such as Medicaid, Medicare, TRICARE, and Veterans Affairs. In addition, we are committed to serving commercial members through employer-sponsored benefits, individual policies and state health insurance exchanges.

Centene operates health plans in 23 states and offers specialty services, such as the management of behavioral health, vision and pharmacy benefits, and more. In Arizona, Centene's plan is Bridgeway Health Solutions, which serves Medicare Special Needs Plan (SNP) beneficiaries and individuals enrolled in the Arizona Health Care Cost Containment System (AHCCCS).

ADDITIONAL INFORMATION

As always, your participation in our network is appreciated. We look forward to future growth and value your continued relationship.

Providers and their staff members are encouraged to access Health Net's provider portal online at *provider.healthnet.com* for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at *provider.healthnet.com* or by telephone at 1-888-788-4408.

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CONTRACTUAL | MARCH 9, 2016 | UPDATE 16-101 | 2 PAGES

Health Net Access™

Adult Health Maintenance Medical Record Documentation

Health Net Access, Inc. requires that providers adhere to Health Net Access standards for maintaining member medical records and to all state and federal laws to safeguard the confidentiality of medical information. Health Net Access regularly monitors medical record documentation compliance.

Recently, Health Net Access reviewed, aggregated and analyzed select medical records and identified opportunities for improvement. Rates of documentation and compliance in health maintenance have been consistently below Health Net Access' compliance threshold of 85 percent.

DOCUMENTATION ELEMENTS

Health Net Access identified deficiencies that require improvement as listed on page two. Health Net Access encourages providers to review office policies, procedures and processes to improve their overall documentation with a focus on the identified deficiencies.

As a reminder, documentation in member medical records must include:

- Discussion with the member regarding his or her need for tests.
- Tests ordered by the provider.
- Referral provided to member.
- Tests performed and results listed in the member's medical record.
- Note or letter from provider indicating who performed testing (such as a note in the member's medical record stating urology consultant performed prostate exam).
- Immunizations that were offered, administration of immunization or member's refusal of immunization, and immunizations that were administered from other sources (such as Walgreens, CVS, etc.).

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- ○ Ancillary Providers

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OTH006241EH00 (3/16)

ADULT HEALTH MAINTENANCE DOCUMENTATION ELEMENTS

The following examinations and screenings were deficient in a recent review. Providers must focus on improving these rates.

Examinations and Screenings	Ages (in years)	Frequency
WOMEN		
Breast exam	19–39	Every 1–3 years
	40 and older	Annually
Pelvic exam with Pap test	19–25	Every 3 years
	26–39	May require co-testing with cytology every 5 years or cytology alone every 3 years
	40–65	Co-testing every 5 years; cytology alone every 3 years
	65 and older	None needed after prior negative screening results
Chlamydia/gonorrhea screening	19–25	Annually for sexually active women under age 24
	26 and older	Annually if high risk
Mammography	19–39	N/A
	40 and older	Annually
MEN		
Prostate cancer screening (PSA lab or digital rectal exam)	19–39	N/A
	40 and older	Discuss with provider
MEN AND WOMEN		
Fasting lipid profile	19–25	If at risk
	35 and older	Every 5 years
Fecal occult blood test (FOBT)	40–49	If at risk
	50 and older	Highly sensitive fecal occult blood test annually; sigmoidoscopy every 5 years with FOBT every 3 years; colonoscopy every 10 years
Influenza vaccine	19 and older	Annually
Pneumonia vaccine	19 and older	Once

PROVIDER*Update*

CONTRACTUAL | FEBRUARY 9, 2016 | UPDATE 16-067 | 1 PAGE

Health Net Access™

Notice: Ownership Change for Health Net in Process

Health Net and Centene are in the process of an ownership change whereby Centene would acquire Health Net, including the Health Net Access plan. Health Net and Centene are committed to quality health care and view this change as an opportunity to pursue higher levels of quality and access to health care services for our members and excellent customer support for our providers.

HOW DOES THIS AFFECT HEALTH NET ACCESS PROVIDERS?

At this time there are no plans to change current Health Net Access provider contractual arrangements. Any future operational changes will be communicated to providers through Health Net Access provider updates and the Health Net Access website. Providers will continue to receive quality customer service from our current provider services staff now and during any transition activities.

HOW CAN A PROVIDER GET MORE INFORMATION?

As discussion continues, Health Net Access providers can stay informed through our website or by contacting the Provider Services Center at 1-888-788-4408, which is available 24 hours a day, 7 days a week.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

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PROVIDER*Update*

NEWS & ANNOUNCEMENTS | FEBRUARY 5, 2016 | UPDATE 16-055 | 1 PAGE

Health Net Access™

2016 Provider Teleconferences

Health Net Access, Inc. is offering a variety of educational teleconferences in 2016 to physicians, case managers, nurses, and other staff who work with Health Net Access members. Health Net Access offers continuing education hours for nurses[1] for all teleconferences, and St. Joseph's Hospital and Medical Center offers continuing medical education (CME)[2] credits for all teleconferences. Teleconferences are scheduled from 12:00 p.m. to 1:00 p.m. Pacific time (PT) unless otherwise specified below, and topics and dates, which are subject to change, are as follows:

Topic	Date
Special Needs Plan (SNP) Model of Care	February 17, 2016
Asthma	March 23, 2016
Osteoporosis and Bone Health	April 20, 2016
Diabetes	May 18, 2016
Cardiac Health	June 15, 2016
Healthcare Effectiveness Data and Information Set (HEDIS®) Best Practices and Update	August 17, 2016
Flu/FOBT/FIT (colorectal cancer screening)	September 21, 2016
Quality Outcomes	November 16, 2016

Some of the topics are linked to the Centers for Medicare & Medicaid Services (CMS) Five-Star Quality Rating System measures. Health Net Access encourages provider attendance and engagement at these educational teleconferences to address health care gaps and achieve better patient outcomes and patient satisfaction.

REGISTRATION

Providers can register for these teleconferences via email to cqi_medicare@healthnet.com. Health Net Access sends a confirmation email with call-in information and meeting materials to registered participants prior to the teleconference. After the teleconference, attendees are sent a survey and instructions for obtaining continuing education units (CEUs) and CMEs.

[1] Provider-approved by the California Board of Registered Nursing, provider number CEP 13156, for contact hour.

[2] This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of St. Joseph's Hospital and Medical Center and Health Net. St. Joseph's Hospital and Medical Center is accredited by ACCME to provide continuing medical education for physicians. St. Joseph's Hospital and Medical Center designates these live activities for a maximum of 1 AMA PRA Category 1 *Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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PROVIDER*Update*

NEWS & ANNOUNCEMENTS | FEBRUARY 2, 2016 | UPDATE 16-040 | 1 PAGE

Health Net Access™

Health Net Access Provider Relations and Claims Educator Contacts

Based on Arizona Health Care Cost Containment System (AHCCCS) feedback to a recent a provider claims survey, Health Net Access, Inc. is making available a list of provider relations representatives and claims educators contact information to Health Net Access providers. Providers may contact them with inquiries about Health Net Access.

	Name	Contact Information
MANAGER, PROVIDER RELATIONS OPERATIONS	Filiberto Gurrola	telephone: (602) 794-1486 fax: 1-855-563-0985 filiberto.l.gurrola@healthnet.com
SENIOR PROVIDER RELATIONS REPRESENTATIVE	Karen Ellington	telephone: (602) 794-1584 fax: 1-800-544-0210 karen.m.ellington@healthnet.com
CLAIMS EDUCATORS	Mary Niles	telephone: (602) 794-1407 fax: 1-855-704-4628 mary.l.niles@healthnet.com
	Renee Garcia	telephone: (602) 794-1632 fax: 1-855-427-4582 renee.c.garcia@healthnet.com
	Valerie Noor	telephone: (602) 794-1503 fax: 1-855-427-4582 valerie.a.noor@healthnet.com
PROVIDER RELATIONS REPRESENTATIVES	Colleen Campos	telephone: (602) 794-1409 fax: 1-855-299-5192 colleen.m.campos@healthnet.com
	Nala Bennett	telephone: (602) 794-1577 fax: 1-855-247-4018 nala.x.bennett@healthnet.com
	Vanessa Correa	telephone: (602) 794-1559 fax: 1-877-641-1938 vanessa.c.correa@healthnet.com
	Zobeida Montosa	telephone: (602) 794-1505 fax: 1-877-714-3305 zobeida.x.montosa@healthnet.com
COMMUNITY SOLUTIONS SPECIALIST	Tina Brown	telephone: (602) 794-1492 tina.m.brown@healthnet.com

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PROVIDER*Update*

CONTRACTUAL | JANUARY 25, 2016 | UPDATE 16-027 | 2 PAGES

Health Net Access™

Medical Policies – 4th Quarter 2015

This provider update includes a listing of updated clinical practice guidelines, and new and updated Health Net Access, Inc. medical policies approved by the Health Net National Medical Advisory Council (MAC) in the fourth quarter of 2015. For a complete description of new and updated medical policies, visit the Health Net provider website at provider.healthnet.com and select *Working with Health Net > Medical Policies*.

PURPOSE OF HEALTH NET MEDICAL POLICIES

Medical policies provide guidelines for determining medical necessity for specific procedures, equipment and services. All services must be medically necessary to be eligible for benefit coverage, unless otherwise defined in the member's benefits contract. The determination for coverage is also based on all of the terms of the individual member's benefits contract, including, but not limited to, eligibility at the time of service and description of covered benefits, limitations and exclusions. In some cases, legal or regulatory mandate requirements may be applicable and may prevail over medical policy. To the extent there are any conflicts between medical policy guidelines and applicable benefit contract language, the benefit contract language prevails. Medical policy is not intended to override the *Member Handbook* or the health insurance policy that defines the member's benefits, nor is it intended to provide medical advice or dictate to providers how to practice. If required, prior authorization must be obtained before services are rendered.

Clinical Practice Guideline Updates

Guideline	Change
ATTENTION DEFICIT HYPERACTIVITY DISORDER IN CHILDREN AND ADOLESCENTS	Minor revisions. Updated references

New Policy

Medical Policy	Policy Statement
PULMONARY ARTERY PRESSURE MONITORING (CARDIOMEMS™)	Wireless devices that monitor pulmonary pressure, such as CardioMEMs™, are considered investigational at this time because of insufficient evidence in the current medical literature to assess long-term outcomes as compared to standard management of chronic heart failure

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Updated Policies

Medical Policy	Change
ENDOVASCULAR AAA REPAIR	Added the use of fenestrated endovascular stent graft, such as Zenith® Fenestrated AAA Endovascular Graft, investigational due to insufficient data on the long-term safety and effectiveness of this device
GROWING ROD SURGERY	Revised policy statement to consider traditional growing rods or magnetically controlled growing rods medically necessary when criteria are met
HEART TRANSPLANT (ADULT OR ADOLESCENT)	Removed age limitations from policy statement based on recommendation to focus physiologic age with emphasis on the functional integrity of major organ systems and the absence of exclusionary comorbid diseases
LYMPHEDEMA AND VENOUS STASIS ULCER TREATMENTS	Added suction-assisted protein lipectomy to the investigational section of the policy that addresses surgical interventions
ONCOTYPE FOR CANCER	Added node status of "1–3 involved ipsilateral axillary lymph nodes" based on National Comprehensive Cancer Network (NCCN) recommendation (V.3.2015) for breast cancer. Removed other gene assay information and moved it into the Mammaprint policy since this policy only addresses oncotype testing
PHYSICAL AND OCCUPATIONAL THERAPY	Revised definition of habilitative services to reflect state definitions
PROPHYLACTIC MASTECTOMY	Under section on Bilateral Prophylactic Mastectomy, revised criteria #2, removing specific genetic mutations (BRCA1 or BRCA2, PTEN, TP53, CDH1, STK11) and adding a note that the option of risk-reduction mastectomy is warranted based on gene and/or risk level (such as BRCA1, BRCA2, CDH1, PTEN, and TP53) and on family history or other clinical factors as per NCCN recommendations on breast cancer risk reduction (2.2015)
PROTEOMIC-BASED TESTING FOR OVARIAN CANCER	Added Risk of Ovarian Malignancy Algorithm (ROMA™) for the detection of ovarian cancer as investigational
SPEECH THERAPY	Revised definition of habilitative services to reflect state definitions
TUMOR MARKERS FOR CANCER	Added ThyGenX® Thyroid Oncogene Panel/ThyraMIR™ (predecessor – miRInform® Thyroid) and ThyroSeq® v.2 Next Generation Sequencing Panel as investigational
WOUND CARE	Revised EpiFix® to be considered medically necessary when criteria are met and added Aurix™ to investigational section

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

PROVIDER*Update*

CONTRACTUAL | JANUARY 15, 2016 | UPDATE 16-003 | 2 PAGES

Provider Demographic Data Verification Reminder

To ensure Health Net Access, Inc. members have access to accurate information when selecting providers, providers are required to provide advance notification to Health Net Access, their medical groups or independent practice associations (IPAs) when they have changes to their demographic information. On a monthly basis, providers should validate that their demographic information is reflected correctly on the provider website at www.healthnet.com under ProviderSearch.

DEMOGRAPHIC INFORMATION

Providers' demographic data 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 Access must notify Health Net Access of changes by completing the online form, which is available on the provider website at provider.healthnet.com under *Manage My Account > Account Management Tools > Update Provider Information.*

As stated in the *Provider Participation Agreement (PPA)*, providers are required to provide a minimum of 30 days advance notice of any changes to their demographic information. If the change pertains to the status of accepting new patients, the provider must notify Health Net Access or the applicable medical group or IPA within five business days.

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 Access. Medical groups and IPAs must have policies in place that establish and implement processes to collect, maintain and submit their provider demographic changes to Health Net Access on a real-time basis. Real-time is within 30 days, as recently defined by the Centers for Medicare & Medicaid Services (CMS). In 2016, Health Net Access begins conducting random audits of medical groups and IPAs to validate processes and policies to ensure they are maintaining provider demographic information on a regular basis.

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Update Your Info Online

Is your demographic information current for Health Net provider directories and the online ProviderSearch function? Submit updates and corrections, including information regarding practice locations, provider names, languages spoken at the practice, and office hours, on the provider website at provider.healthnet.com by selecting *My Account > Update Provider Information.*

PROVIDER*Update*

NEWS & ANNOUNCEMENTS | JANUARY 12, 2016 | UPDATE 16-001 | 2 PAGES

Health Net Access™

Health Net Access Performance Improvement Projects

Health Net Access, Inc. participates in Arizona Health Care Cost Containment System (AHCCCS)-mandated performance improvement projects (PIPs) that take into account comprehensive aspects of members' needs, care and services. PIPs measure the impact of interventions or activities toward improving quality of care and service delivery. Health Net Access PIPs include e-prescribing and two new PIPs: controlled substance prescription monitoring program database use and early identification and treatment of developmental issues. Health Net Access encourages providers to support these PIPs as a component of the quality management (QM) program.

E-PRESCRIBING

Providers may send prescriptions directly to pharmacies from members' points of care through electronic prescribing (e-prescribing). E-prescribing allows providers to safely and efficiently manage members' medications while reducing the risk for errors.

Potential benefits of e-prescribing include:

- A direct and immediate connection with the member's pharmacy.
- Reduction in potential adverse drug events and potential errors.
- Reduction in overall costs related to improved formulary compliance and use of generic alternatives.
- Improved management of time and work-flow efficiency at the practice level.
- Improved member satisfaction – members can make one trip to the pharmacy to pick up the medication rather than drop off the prescription and wait to have the prescription filled, or make a second trip to the pharmacy to pick up the medication.
- Improved efficiency at the pharmacy level, with less time spent interpreting handwriting or rekeying medication information into the computer system.
- Improved medication adherence in chronic disease conditions.
- Reduced medication costs as a result of increased formulary compliance and use of generics and other low-cost alternatives.
- Improved overall quality of care provided.

CONTROLLED SUBSTANCE PRESCRIPTION MONITORING PROGRAM DATABASE USE

Health Net Access aims to increase participation in the Arizona Controlled Substances Prescription Monitoring Program (CSPMP). Health Net Access requests that participating providers register online at pharmacypmp.az.gov and begin accessing patient information through CSPMP. Potential benefits of using CSPMP include:

- Improved coordination of care and prescribing.

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- Decreased adverse outcomes, such as unexpected deaths, hospitalizations or infants born with opioid addictions.
- Reduction in prescriber shopping (specifically, fewer visits to emergency departments, primary care providers, etc.)

EARLY IDENTIFICATION AND TREATMENT OF DEVELOPMENTAL ISSUES

Health Net Access aims to increase providers' use of developmental screening tools, such as Parent's Evaluation of Developmental Status (PEDS), Ages and Stages Questionnaire (ASQ) and Modified Checklist for Autism in Toddlers (M-Chat). Increasing the use of developmental screening tools may help with the following:

- Earlier identification of children with developmental issues.
- Increased referrals for treatment of children with developmental issues.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

PROVIDER*Update*

NEWS AND ANNOUNCEMENTS | DECEMBER 11, 2015 | UPDATE 15-687 | 3 PAGES

Health Net Access™

Updated Health Net Access Performance Measures

The Arizona Health Care Cost Containment System (AHCCCS) measures the quality of care provided to members through several avenues, including AHCCCS-established performance metrics. For the contract year that runs October 1, 2015, to September 30, 2016, Health Net Access will be reporting rates for over 30 AHCCCS-established performance measures to AHCCCS on a quarterly basis. Health care providers can positively impact the rates by providing patients with the recommended immunizations and preventive screenings included in the measures listed in the following tables.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

Adult's Performance Measure	Minimum Performance Standard (MPS)
Inpatient utilization	TBD
Ambulatory care – emergency department (ED) visits	TBD
Readmissions within 30 days of discharge	TBD
Adult asthma admission rate	TBD
Use of appropriate medications for people with asthma	86%
Follow-up after hospitalization (all cause) within 7 days	50%
Follow-up after hospitalization (all cause) within 30 days	70%
Adults' access to preventive/ambulatory health services	75%
Breast cancer screening	50%
Cervical cancer screening: women ages 21–64 with a cervical cytology performed every 3 years	64%
Cervical cancer screening: women ages 30–64 with a cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years	64%
Chlamydia screening in women ages 16–24	63%

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Children's Performance Measures	Minimum Performance Standard (MPS)
Children's access to PCPs ages 12–24 months	93%
Children's access to PCPs, ages 25 months to 6 years	84%
Children's access to PCPs, ages 7–11	83%
Adolescent's access to PCPs, ages 12–19	82%
Well-child visits, age 15 months	65%
Well-child visits, ages 3–6	66%
Adolescent well-child visits, ages 12–21	41%
Children's dental visits, ages 2–21	60%
Weight assessment and counseling. Body mass index (BMI) assessment for children/adolescents[1]	50%
Early and periodic screening, diagnosis and treatment (EPSDT) participation	68%
Percentage of eligibles who received preventive dental services *(previously titled EPSDT Dental Participation)*	46%
Ambulatory care – emergency department (ED) visits	TBD
Inpatient utilization	TBD
Hospital readmission rate	TBD
Developmental screening in the first three years of life[1]	55%
Comprehensive Diabetes Management Measures	**Minimum Performance Standard (MPS)**
HbA1c testing	77%
HbA1c poor control (>9.0%)[1]	TBD
LDL-C screening	70%
Eye exam	49%
Flu shots for adults, ages 18+[1]	50%
Diabetes admissions, short-term complications	TBD
Chronic obstructive pulmonary disease (COPD)/asthma in older adults admissions	TBD
Asthma in younger adults admissions	TBD

Congestive heart failure admissions	TBD
Annual monitoring for patients on persistent medications: combo rate	75%
Timeliness of prenatal care: prenatal care visit in the first trimester or within 42 days of enrollment	80%
Prenatal and postpartum care: postpartum care rate (second component to Children's Health Insurance Program Reauthorization Act (CHIPRA) core measure timeliness of prenatal care)	64%
Childhood Immunization Status	**Minimum Performance Standard (MPS)**
DTaP	85%
IPV	91%
MMR	91%
Hib	90%
HBV	90%
VZV	88%
PCV	82%
4:3:1:3:3:1 series	74%
4:3:1:3:3:1:4 series	68%
Hepatitis A (HAV)	40%
Rotovirus	60%
Influenza	45%
Immunizations for Adolescents	**Minimum Performance Standard (MPS)**
Adolescent meningococcal	75%
Adolescent Tdap	75%
Adolescent combo	75%
Human papillomavirus vaccine for female adolescents[1]	50%

[1]New measures for 2016, effective October 1, 2015.

PROVIDER*Update*

CONTRACTUAL | NOVEMBER 24, 2015 | UPDATE 15-627 | 1 PAGE

Health Net Access™

Updated Codes for Hospital Outpatient Services

The Centers for Medicare & Medicaid Services (CMS) has updated Place of Service (POS) codes to specify where a hospital outpatient service was provided. The following new and revised POS codes apply to claims for Health Net Access.

Effective January 1, 2016, providers must submit the appropriate POS code listed below when submitting claims for hospital outpatient services:

- POS 19 (Off Campus – Outpatient Hospital) – new for outpatient services performed at an off-campus hospital for diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services.
- POS 22 (On Campus – Outpatient Hospital) – revised for outpatient services performed on a hospital campus for diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services.

Providers should notify their billing staff so they are aware of the changes and use the appropriate POS codes when submitting hospital claims.

ADDITIONAL INFORMATION

Additional information regarding the updated POS codes is also available in the CMS MLN Matters MM9231 publication online at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9231.pdf.

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Update Your Info Online

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PROVIDER*Update*

NEWS & ANNOUNCEMENTS | NOVEMBER 23, 2015 | UPDATE 15-625 | 2 PAGES

Health Net Access™

Enrolling in ERA and EFT

This communication reminds providers that Health Net Access, Inc. offers electronic remittance advice (ERA) and electronic funds transfer (EFT) to expedite payments, reduce administrative work and check-processing expenses. Enrollment for ERA and EFT is outlined below.

ERA

ERA provides details about multiple claims and helps improve business office workflow by allowing the adjudicated claim information to be automatically posted to accounts receivable systems. Health Net, Inc. (Health Net) sends an ERA to any provider who registers with an approved clearinghouse. ERA complies with Health Insurance Portability and Accountability Act (HIPAA) ASCX12 835 requirements making it consistent with other payers and is acceptable nationwide.

Enrolling for ERA

Providers may submit the ERA enrollment form online or download it and send it to Health Net via email or fax.

Online enrollment is available on Health Net's provider website at provider.healthnet.com under *Transactions* > *Claims* > *ERA – Electronic Remittance Advice Online Enrollment.*

If the provider prefers to email or fax the enrollment form, it is available on Health Net's provider website at provider.healthnet.com under *Transactions* > *Claims* > *ERA – Electronic Remittance Advice Authorization Agreement.* Complete the form and submit it to Health Net Access via email at edi.support@healthnet.com or by secure fax to 1-800-677-4147, Attention: EDI Business. Providers must also enroll with their clearinghouse.

EFT

EFT automates the distribution of funds into accounts using automated clearinghouse processing to reconcile accounts receivable, which provides significant savings in check processing fees. Before EFT, providers were required to open the mail, pull the check, enter the data into their systems, get the checks to the bank, wait for them to clear, reconcile books, and more. EFT is safe, secure, efficient, and less expensive than paper check payments and collections.

Enrolling for EFT

Providers may submit the EFT enrollment form online or download it and send it to Health Net via email or fax.

Online enrollment is available on Health Net's provider website at provider.healthnet.com under *Transactions* > *Claims* > *EFT – Electronic Funds Transfer Online Enrollment.*

If the provider prefers to email or fax the enrollment form, it is available on Health Net's provider website at provider.healthnet.com under *Transactions* > *Claims* > *EFT – Electronic Funds Transfer Authorization Agreement.* Complete the form and

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submit it, along with a voided check, to Health Net via email at edi.support@healthnet.com or by secure fax to 1-800-677-4147, Attention: EDI Business.

ADDITIONAL INFORMATION

Providers are encouraged to access the Health Net provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

Update Your Info Online

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PROVIDER*Update*

NEWS & ANNOUNCEMENTS | NOVEMBER 17, 2015 | UPDATE 15-612 | 1 PAGE

Health Net Access™

Statewide Plan to Integrate Physical and Behavioral Health Information

Arizona Health Care Cost Containment System (AHCCCS) has announced that The Network, Arizona's statewide health information exchange (HIE) operated by Arizona-e Connection (AzHeC), has begun developing a statewide plan to integrate physical and behavioral HIE under one infrastructure. The goal is to facilitate secure sharing of patient information among medical and behavioral health care providers.

AHCCCS ANNOUNCEMENT

The attached AHCCCS announcement provides details of the integration plan.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

Update Your Info Online

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The Network to Develop a Statewide Plan for Integrated Physical & Behavioral HIE

The Network, Arizona's statewide HIE operated by Arizona Health-e Connection (AzHeC), has begun the development of a statewide plan to integrate physical and behavioral health information exchange (HIE) under one infrastructure. This effort, funded by the State of Arizona in collaboration with the Arizona Regional Behavioral Health Authorities (RBHAs), aims to incorporate work that has been done to date by The Network, the RBHAs and Behavioral Health Information Network of Arizona (BHINAZ) to facilitate the secure sharing of patient information by behavioral and medical health care providers. While the plan will outline considerable detail on marketing and messaging, sustainability, participation and connectivity costs as well as implementation timelines, the overall objective will be to develop a single statewide HIE infrastructure for the sharing of physical and behavioral health information with a single participation fee for physical and behavioral health providers.

The goal ultimately is to improve quality and outcomes for Arizona patients who receive physical and behavioral health care, according to Tom Betlach, Director of AHCCCS. "There is clear value in integrating physical and behavioral health information to allow providers access to more complete records on their patients," Betlach said. "This plan will build on the work that has been done by The Network, BHINAZ, the RBHAs and the State of Arizona to enable the secure sharing of physical and behavioral health through one HIE infrastructure. As we move toward an integrated delivery system, we need to have an HIE that supports providers in developing integrated delivery service models."

The plan will be designed to contain these essential elements:

- A single HIE infrastructure managed by The Network;
- One marketing, communications and messaging strategy for the integrated HIE for all physical and behavioral services; and
- One financial model that encompasses a single fee for both physical and behavioral health care stakeholders to sustain the integrated physical and behavioral health network.

The State is supporting the development of a single statewide HIE built on The Network for a variety of reasons. As a part of AzHeC, The Network's non-profit governance structure is transparent and broad-based, led by providers, payers and the community. Under this governance model, providers representing the full continuum of care have the opportunity to participate in the decision-making process of developing this important infrastructure. Nationally, the sustainability of HIEs is a very difficult operational challenge. Therefore, Arizona must support a single, sustainable, integrated, transparent Network with an appropriate governance structure where all providers have an ownership stake.

The Network is utilizing nationally known subject-matter experts and consultants to assist in the development of the plan. The integrated statewide plan is expected to be complete by the end of this year. The plan with results, findings and recommendations will be submitted to the State for review and approval. As part of this process, the State of Arizona will evaluate opportunities to cover some of the provider connectivity and operating costs similar to a current program that provides HIE connectivity funding for hospitals and FQHCs. Funding of this nature helps to offset the cost of HIE connectivity for Network participants; as a result, the AzHeC and Network Boards recently approved the elimination of participation fees for community providers in 2016. Look for more information and updates on this plan in Updates and Alerts from AzHeC.

Sign up to start receiving the AzHeC Update, The Network News and important Alerts. To subscribe click here

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Health Net Access™

NEWS & ANNOUNCEMENTS | NOVEMBER 6, 2015 | UPDATE 15-583 | 2 PAGES

Summary of Select 2015 Health Net Access Provider Communications

This update highlights select Health Net Access, Inc. communications distributed to providers in 2015 that applied to the General Mental Health and Substance Abuse (GMH/SA) integration. A complete list of provider communications, including those mentioned below, is available on the provider website at provider.healthnet.com in the Provider Library under *Updates and Letters > 2015*.

- Provider update 15-366, *General Mental Health and Substance Abuse Benefit Integration for Dual-Eligible Members*, distributed on July 24, 2015.
- Provider letter 15-435, *Controlled Substance Prescription Monitoring Program* letter, distributed August 28, 2015.
- Provider update 15-472, *Interpreter Services and Cultural Training*, distributed September 10, 2015.

GENERAL MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT INTEGRATION FOR DUAL-ELIGIBLE MEMBERS

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

General Mental Health and Substance Abuse Forum Presentation

Health Net Access Provider Network Management hosted a GMH/SA forum for Health Net Access providers on September 23, 2015. Forum topics included the claims and appeals process, prior authorization process and behavioral health treatment. A presentation of the forum is available on the provider website at provider.healthnet.com pre-login under *Working with Health Net > AHCCCS Information.*

REGISTERING FOR THE CONTROLLED SUBSTANCE PRESCRIPTION MONITORING PROGRAM

As part of our commitment to the Sign Up to Save Lives campaign, Health Net Access requests that participating providers in Maricopa County register online at pharmacypmp.az.gov and participate in the Arizona Controlled Substances Prescription Monitoring Program (CSPMP). CSPMP was developed to promote public health and welfare by detecting diversion, abuse and misuse of prescription medications classified as controlled substances under the Arizona Uniform Controlled Substances Act.

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INTERPRETER SERVICES AND CULTURAL TRAINING

Health Net Access offers participating physicians, medical groups, ancillary providers, and members 24-hour access to telephonic interpreter services. Additionally, Health Net Access offers in-person interpreter services, as well as sign language assistance, during business hours at no cost.

Information is also available about Health Net Access interpreter services contacts, cultural and linguistic appropriateness, provider responsibilities, and cultural competency training from the United States Department of Health and Human Services' Office of Minority Health (OMH).

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

Update Your Info Online

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Health Net Access™

Health Net Access
Provider Forum

Register today for Health Net Access provider training

Health Net Access, Inc. Provider Network Management invites you to an upcoming provider forum for Health Net Access providers. This no-cost training is designed for Health Net Access primary care physicians (PCPs), obstetricians and gynecologists (OB/GYNs), and specialists, as well as their staff, including billing teams.

Date:

Tuesday, November 17, 2015
11:00 a.m. to 2:00 p.m., Mountain time (MT)
Lunch will be provided.

Place:

Thunderbird School of Global Management
AT&T Auditorium
1 Global Place, Glendale, AZ 85306

RSVP:

Tuesday, November 10, 2015,
via fax or online, to be entered into a raffle for a gift card.

Fax: **(602) 794-1803** or sign up online at **events.SignUp4.com/2015Access**

Who should attend?

- PCPs, OB/GYNs, specialists, office staff, billers
- Two representatives per office

Presenters include:

- Claims
- Case Management
- Pharmacy
- Quality Management/Improvement
- *Guest speakers:* Adelante Healthcare and Controlled Substance Prescription Monitoring Program

Community resources:

Arizona Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Find Help Phoenix, American Diabetes Association (ADA), Susan G. Komen Central and Northern Arizona, Crisis Response Network, and First Things First.

If you are unable to attend the training, materials will be available on the Health Net provider website at provider.healthnet.com under *Working with Health Net > Regulatory > Health Net Access,* or you may request them from the Health Net Quality Improvement Department via email at AHCCCS_Notification@healthnet.com.

Availability is limited; register soon!

Please complete the registration information below and fax it to the number listed above.

Attendee name (please print)	*Physician/Practice name and tax ID*	*Specialty*	*Telephone*
_____	_____	_____	_____
_____	_____	_____	_____

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PROVIDER*Update*

CONTRACTUAL | NOVEMBER 2, 2015 | UPDATE 15-562 | 3 PAGES

Health Net Access™

Medical Policies – 3rd Quarter 2015

This provider update includes a listing of updated Decision Power® clinical practice guidelines, and retired and updated Health Net Access, Inc. medical policies approved by the Health Net National Medical Advisory Council (MAC) in the third quarter of 2015. For a complete description of new and updated medical policies, visit the Health Net provider website at provider.healthnet.com and select *Working with Health Net > Clinical > Medical Policies*. For descriptions of Decision Power clinical practice guidelines, select *Working with Health Net > Clinical > Decision Power > Clinical Guidelines*.

PURPOSE OF HEALTH NET MEDICAL POLICIES

Medical policies provide guidelines for determining medical necessity for specific procedures, equipment and services. All services must be medically necessary to be eligible for benefit coverage, unless otherwise defined in the member's benefits contract. The determination for coverage is also based on all of the terms of the individual member's benefits contract, including, but not limited to, eligibility at the time of service and description of covered benefits, limitations and exclusions. In some cases, legal or regulatory mandate requirements may be applicable and may prevail over medical policy. To the extent there are any conflicts between medical policy guidelines and applicable benefit contract language, the benefit contract language prevails. Medical policy is not intended to override the *Member Handbook* or the health insurance policy that defines the member's benefits, nor is it intended to provide medical advice or dictate to providers how to practice. If required, prior authorization must be obtained before services are rendered.

Updated Decision Power Clinical Practice Guidelines

Guideline	Change
CORONARY ARTERY DISEASE	Added the following guidelines based on recommendations from the American College of Cardiologists (ACC), the American Heart Association (AHA) and The Obesity Society (TOS): • ACC/AHA Guideline on the Assessment of Cardiovascular Risk, 2013 • ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Arteriosclerotic Cardiovascular Risk in Adults (ATP4), 2013 • AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults, 2013 • AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk, 2013

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Updated Decision Power Clinical Practice Guidelines, continued

Guideline	Change
CORONARY ARTERY DISEASE, CONTINUED	Added the following guideline from the Joint National Committee (JNC8): • Evidence-Based Guideline for the Management of High Blood Pressure in Adults, 2014
CHRONIC OBSTRUCTIVE PULMONARY DISEASE	• Revised risk assessment chart to include hospitalizations • Revised pharmacologic patient groups
DIABETES	Revisions based on American Diabetes Association Practice Recommendations in 2014 for both adults and children that include monitoring, nutritional therapy, and detection of retinopathy, neuropathy and nephropathy

Updated Policies

Medical Policy	Change
BIVENTRICULAR PACEMAKERS – CARDIAC RESYNCHRONIZATION DEVICES	Revised policy statement to be consistent with class I and IIa recommendations from ACC/AHA Guideline on the Management of Heart Failure (2013)
DISC DECOMPRESSION PROCEDURES – PERCUTANEOUS AND LASER	These procedures are considered not medically necessary since the peer-reviewed evidence-based literature and the various position statements note a paucity of long-term outcomes. Clinical studies have not established clinically significant benefit of use of a laser over use of a scalpel for percutaneous lumbar discectomy
FERTILITY PRESERVATION FOR CANCER PATIENTS	Added cryopreservation of mature oocytes in women as medically necessary prior to commencing treatment that is likely to affect fertility. Coverage is subject to member benefits and *Evidence of Coverage* documents
GENETIC TESTING FOR BRCA1 AND BRCA2	Added revised guidelines from the National Comprehensive Cancer Network (NCCN) Guidelines on Genetic/Familial High-Risk Assessment of Breast and Ovarian Cancer (V.2.2015)
GENETIC TESTING FOR FAMILIAL ADENOMATOUS POLYPOSIS (FAP)	Added genetic testing for FAP as medically necessary for individuals with a personal history of desmoid tumor
GENETIC TESTING INDICATIONS	• Added genetic testing as medically necessary for oncology patients with unexplained or pre-existing familial neuropathy consistent with Charcot-Marie-Tooth disease, and for prenatal or preimplantation genetic diagnosis of Charcot-Marie-Tooth disease type 1A • Added as medically necessary factor V Leiden (FVL) or prothrombin gene (G20210) mutation testing for oral contraceptive use in women with a personal history of venous thromboembolism (VTE) or a family history of VTE that includes a first-degree relative with VTE associated with factor V Leiden or deficiency. Routine screening for factor V Leiden and similar types of genetic testing in women with no personal or family history is considered not medically necessary

Updated Policies, continued

Medical Policy	Change
GLAUCOMA SURGERY	• Added laser trabeculoplasty, trabeculectomy and U.S. Food and Drug Administration (FDA) approved aqueous shunts to the medically necessary section of the policy • Added nonpenetrating glaucoma surgery (such as viscocanalostomy and nonpenetrating deep sclerectomy), ab interno trabeculotomy using the Trabectome system, and transciliary fistulization using Fugo blade to the investigational section of the policy
LEFT ATRIAL APPENDAGE DEVICES	Added Watchman™ procedure as medically necessary to reduce the risk of stroke in adult patients with nonvalvular atrial fibrillation (NVAF) who have failed or have contraindications to warfarin and other antithrombin anticoagulants
LUNG TRANSPLANTATION	Based on a consensus document from the International Society for Heart and Lung Transplantation (ISHLT 2014), revised criteria under indications for transplant for obstructive lung disease, cystic fibrosis and primary pulmonary hypertension. Added additional contraindications and relative contraindications
PHYSICAL AND OCCUPATIONAL THERAPY	Added statement to check for state-specific mandates that allow for direct access (without a physician order) for physical therapy services
PROSTATIC URETHRAL LIFT	The UroLift® is now considered medically necessary as an alternative for select patients who require surgical treatment for benign prostatic hypertrophy (BPH) and meet specific criteria noted in the policy statement
TRANSCRANIAL MAGNETIC STIMULATION (TMS)	Removed criterion number 7 under the policy statement section that required the patient to have had a good response to previous TMS treatment
TUMOR MARKERS FOR CANCER	Added Oncotype DX® Prostate Cancer Assay and Decipher® Prostate Cancer Classifier to the investigational section of the policy
WIRELESS CAPSULE ENDOSCOPY (WCE)	Added WCE as medically necessary for re-evaluation of individuals with established Crohn's disease who continue to be symptomatic despite treatment, when there is no suspected or confirmed gastrointestinal obstruction, stricture or fistulae

RETIRED MEDICAL POLICIES

The following medical policies have been retired:

- Home Prothombin and International Normalized Ratio (INR) Monitoring
- Hysteroscopic Tubal Occlusion for Permanent Contraception (Essure®/Adiana®)
- Vitrectomy Support Systems

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

PROVIDER*Update*

NEWS & ANNOUCEMENTS | OCTOBER 22, 2015 | UPDATE 15-534 | 3 PAGES

Health Net Access™

2015–2016 Influenza Vaccine Recommendations

On August 7, 2015, the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) released the Prevention and Control of Influenza with Vaccines Report regarding the use of vaccines to prevent and control influenza for the 2015–2016 season.

The comprehensive ACIP report is available online at www.cdc.gov/mmwr/preview/mmwrhtml/mm6430a3.htm and includes complete influenza vaccine recommendations for the 2015–2016 season. The information in this update highlights some, but not all, documentation of the report.

VACCINE HIGHLIGHTS

Routine vaccine recommendations apply only to individuals ages six months and older who do not have contraindications to vaccine use. Health care providers should begin offering vaccinations as soon as they become available. The vaccine should continue to be offered throughout the flu season as long as it is available since influenza may not appear in certain communities until May.

Additional information from the ACIP report includes the following topics for the 2015–2016 season:

- Groups recommended for vaccination and timing of vaccination.
- Available vaccine products and indications.
- Vaccine dose considerations for children ages 6 months through 8 years.
- Considerations for the use of Live Attenuated Influeza Vaccine (LAIV) and Inactivated influenza vaccine when either is available.
- Influenza vaccine for individuals with a history of egg allergies.
- Vaccine selection and timing of vaccination for immunocompromised individuals.

Different influenza vaccine preparations have different indications as licensed by the United States Food and Drug Administration (FDA). For the most current information regarding influenza vaccine recommendations, visit the CDC website at www.cdc.gov/flu.

INFLUENZA VACCINE COMPOSITION FOR 2015–2016

U.S. trivalent influenza vaccines for 2015–2016 contain hemagglutinin (HA) derived from an A/California/7/2009 (H1N1)-like virus, an A/Switzerland/9715293/2013 (H3N2)-like virus, and a B/Phuket/3073/2013-like (Yamagata lineage) virus. This represents changes in the influenza A (H3N2) virus and the influenza B virus as compared with the 2014–2015 season. Quadrivalent influenza vaccines contain these vaccine viruses and a B/Brisbane/60/2008-like (Victoria lineage) virus, which is the same Victoria lineage virus recommended for quadrivalent formulations in 2013–2014 and 2014–2015.

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VACCINE DISTRIBUTION AND ORDERING INSTRUCTIONS

The influenza vaccine is being distributed through local vendors and distributors. For the 2015–2016 season, most preparations are available for purchase. Information about distributors who have influenza vaccines is available online at www.preventinfluenza.org. The CDC also provides information for multi-routine, non-routine, and routine vaccinations on their website at www.cdc.gov/vaccines/hcp/vis.

VACCINES FOR CHILDREN PROGRAM

Influenza vaccinations are a benefit for all Health Net Access members over six months of age and are provided by the Vaccines for Children (VFC) program for all eligible members under age 19.

VFC has pre-booked the influenza serum from the CDC for the 2015–2016 influenza season and will notify providers when it becomes available. All influenza vaccines for the 2015–2016 flu season are quadrivalent. The influenza vaccine may not be available for the VFC program at the same time as private influenza doses.

Registered providers may order influenza vaccines monthly through ASIIS/VOMS. The VFC program will have the following seven quadrivalent vaccines available to order for eligible members:

- Fluarix Quad (GSK) – 0.5 ml syringes for individuals ages 3 through 18 (NDC #58160-0903-52)
- FluLaval Quad (GSK) – 5.0 ml multi-dose vial for individuals ages 3 through 18 (NDC #19515-0898-11)
- Flumist Quad (MedImmune) – Intranasal sprayers for individuals ages 2 through 18 (NDC #66019-0302-10)
- Fluzone Quad (Sanofi) – 0.25 ml syringes for children ages 6 months through 35 months (NDC #49281-0515-25)
- Fluzone Quad (Sanofi) – 0.5 ml single dose vials for individuals ages 3 through 18 (NDC #49281-0415-10)
- Fluzone Quad (Sanofi) – 0.5 ml syringes for individuals ages 3 through 18 (NDC #49281-0415-50)
- Fluzone Quad (Sanofi) – 5.0 ml multi-dose vials for individuals ages 6 months through 18 (NDC #49281-0623-15)

Participating providers must submit claims to Health Net for VFC program-supplied immunizations to receive reimbursement for the administration of the immunization. The administration CPT code and the associated VFC vaccine CPT code are required when requesting payment for the administration fee of VFC vaccines.

Providers who need additional doses of the influenza vaccine or more information about the VFC program may contact VFC at (602) 364-3642.

CLAIM SUBMISSION FOR THE NON-VFC INFLUENZA VACCINE

Upon submission of a claim, Health Net reimbursement to providers is in accordance with the terms of the provider's Health Net *Provider Participation Agreement* (*PPA*) and the member's benefit plan design. Refer to the Seasonal Influenza Vaccine Codes table on page 3 for coding information.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

SEASONAL INFLUENZA VACCINE CODES*

CPT/HCPCS Code	Code Description
	ADMINISTRATION CODES
90460	Immunization administration through age 18 via any route of administration, includes counseling of the patient/family; first injection (single or combination vaccine/toxoid)
90461	Each additional immunization administration (list separately in addition to code for primary procedure)
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)
90473	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)
G0008 (Medicare Advantage only)	Administration of influenza virus vaccine
	VACCINE CODES
90655	Influenza virus vaccine, trivalent, split virus, preservative-free, when administered to children ages 6–35 months, for intramuscular use
90656	Influenza virus vaccine, trivalent, split virus, preservative-free, for use when administered to individuals ages 3 and older, for intramuscular use
90657	Influenza virus vaccine, trivalent, split virus, when administered to children ages 6–35 months, for intramuscular use
90658	Influenza virus vaccine, trivalent, split virus, when administered to children ages 3 and older, for intramuscular use
90660	Influenza virus vaccine, trivalent, live, for intranasal use, for individuals ages 2 and older
90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative- and antibiotic-free, for intramuscular use
90662	Influenza virus vaccine, preservative-free, enhanced immunogenicity via increased antigen content
90664	Influenza virus vaccine, pandemic formulation, live, for intranasal use (vaccine pending FDA approval)
90666	Influenza virus vaccine, pandemic formulation, split virus, preservative-free, for intramuscular use (vaccine pending FDA approval)
90667	Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use (vaccine pending FDA approval)
90668	Influenza virus vaccine, pandemic formulation, split virus, for intramuscular route (vaccine pending FDA approval)
90672	Influenza virus vaccine, quadrivalent, live, for intranasal use (code price is per dose – 0.2 mL)
90685	Influenza virus vaccine, quadrivalent, split virus, preservative-free, when administered to children 6–35 months of age, for intramuscular use (code price is per 0.25 mL)
90686	Influenza virus vaccine, quadrivalent, split virus, preservative-free, when administered to individuals 3 years of age and older, for intramuscular use (code price is per 0.5 mL)

*CPT code descriptions were taken from the 2015 AMA CPT Code Handbook. HCPCS code descriptions were taken from the CMS HCPCS Code Sets.

PROVIDER*Update*

CONTRACTUAL | OCTOBER 19, 2015 | UPDATE 15-510 | 1 PAGE

Health Net Access™

Cardiology Services Prior Authorization Reminder

Health Net Access, Inc. has observed an increase in cardiology services performed without prior authorization. As a reminder, cardiology services, procedures and equipment are subject to prior authorization prior to being performed or distributed to Health Net Access members with the exception of emergency services, which do not require prior authorization.

Providers may access the Health Net Access prior authorization requirements and instructions for submitting prior authorization requests on the Health Net provider website both pre- and post-log in. To access the requirements pre-log in, providers can visit provider.healthnet.com and select *Working with Health Net > Policies for Non-Contracting Providers > Services Requiring Prior Authorization* (under Additional Resources). Post-log in, the requirements are available on provider.healthnet.com under *Working with Health Net > Contractual > Services Requiring Prior Authorization,* or in the Health Net Provider Library under *Operations Manuals > Prior Authorization*.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

Provider-Relevant Articles Online

Access informative Online News articles today by logging in to provider.healthnet.com. Select the rotating graphic to read or print articles of interest. Health Net posts new articles each week that cover a variety of topics, such as administrative procedure reminders, quality improvement tips and health care initiatives.

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 OTH04020EH00 (10/15)

PROVIDER*Update*

REGULATORY | OCTOBER 16, 2015 | UPDATE 15-514 | 2 PAGES

Health Net Access™

Fraud, Waste and Abuse Reporting and Training Reminder

This update reminds Health Net Access providers of important information on the federal False Claims Act (FCA), instructions on how to report suspected fraud, waste and abuse (FWA), and provider training requirements for Health Net Access, Inc.

FEDERAL FALSE CLAIMS ACT

In accordance with the FCA, the following acts are unlawful:

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

The FCA is important because it:

- outlines the rights of consumers and providers to take action to combat fraud on behalf of the government
- expands the scope of fraud beyond those who knowingly intend to commit it
- provides protections to those who bring the false claims to light
- establishes stringent penalties for those found guilty

FRAUD, WASTE AND ABUSE

Health care FWA contributes to the rising cost of health insurance, reduces the amount of funds available to pay honest providers, and reduces the available funds used to provide essential medical services for Medicaid patients. Health Net Access investigates allegations of 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, which is 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's Code of Business Conduct and Ethics, or accessing personal information or protected health information (PHI) without authorization

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

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- Medical Groups/IPAs
- Hospitals
- Ancillary Providers

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REPORTING FRAUD, WASTE, ABUSE, OR VIOLATIONS OF STANDARDS OF CONDUCT

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

To report suspected FWA, contact Health Net Access via mail or telephone as listed below:

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

To report potential or actual noncompliance or ethical concerns, contact Health Net Access via mail or telephone as listed below:

Health Net Access Compliance Officer
Susan Gilkey
Mail Stop: AZ-920-04-07
5255 East Williams Circle, Ste. 4000
Tucson, AZ 85711
Health Net's Integrity Line: 1-888-866-1366

FWA TRAINING

Arizona Health Care Cost Containment System (AHCCCS) has launched the Health Plan Provider Fraud module through the AHCCCS website at www.azahcccs.gov/multimedia/CBT/healthplanproviderfraud/healthplanproviderfraudfs.htm. Health Net Access participating providers can use this training module to satisfy the AHCCCS training requirement for educating staff and providers about fraud and abuse.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

Update Your Info Online

Is your demographic information current for Health Net provider directories and the online ProviderSearch function? Submit updates and corrections, including information regarding practice locations, provider names, languages spoken at the practice, and office hours, on the provider website at provider.healthnet.com by selecting *My Account* > *Update Provider Information*.

PROVIDER*Update*

NEWS & ANNOUNCEMENTS | OCTOBER 16, 2015 | UPDATE 15-491 | 1 PAGE

Health Net Access™

Updated 2015 Health Net Access Materials Available Online

Health Net Access, Inc. materials, updated for 2015, are now available online for participating providers and their staff to access at their convenience. The materials include the *Health Net Access Provider Reference Guide* and *Making Practice Perfect – Tools for Working Efficiently with Health Net* provider toolkit. The guide and toolkit are available on the provider website at provider.healthnet.com, under *Working with Health Net > Regulatory > Health Net Access.*

HEALTH NET ACCESS PROVIDER OPERATIONS MANUALS

The Health Net Access provider operations manuals offer participating providers necessary procedural information to ensure Health Net Access members receive appropriate covered services when needed. The manuals were developed specifically for physicians and hospitals serving Health Net Access members. The contents of the manuals are supplemental to the *Provider Participation Agreement (PPA)* and its addenda.

The manuals are located on the provider website at provider.healthnet.com in the Provider Library. The Provider Library includes operational materials targeted to provider type, including operations manuals, provider updates and letters, contacts, and forms. To access the Provider Library, participating providers must register online at provider.healthnet.com.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

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PROVIDER*Update*

NEWS & ANNOUNCEMENTS | OCTOBER 2, 2015 | UPDATE 15-531 | 3 PAGES

Health Net Access™

Correction to Provider Update 15-473

Health Net Access, Inc. distributed provider update 15-473, *Cultural and Linguistic Community Referral Resources*, on September 24, 2015. This communication included the summary Cultural and Linguistic Community Referral Resources contact sheet, which erroneously featured the Health Net logo instead of the Health Net Access logo.

The logo has been corrected and the updated Cultural and Linguistic Community Referral Resources is attached for reference. Providers can also download the revised provider update 15-473 from the Health Net provider portal at provider.healthnet.com under *Working with Health Net > Contractual > Go to the Provider Library.* Once in the Provider Library, select *Updates and Letters > 2015 > 15-473, Cultural and Linguistic Community Referral Resources*.

Participating providers may download a comprehensive list of resources with contact information through the Health Net Access Provider Operations Manual located on the Health Net provider portal at provider.healthnet.com under *Working with Health Net > Contractual > Go to the Provider Library.* Once in the Provider Library, select *Operations Manuals > Quality Improvement > Cultural and Linguistic Services*.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact Health Net Cultural and Linguistic Services at 1-800-977-6750. For all other questions, contact the Health Net Access Provider Services Center at 1-888-788-4408.

Update Your Info Online

Is your demographic information current for Health Net provider directories and the online ProviderSearch function? Submit updates and corrections, including information regarding practice locations, provider names, languages spoken at the practice, and office hours, on the provider website at provider.healthnet.com by selecting *My Account > Update Provider Information*.

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Health Net Access™

Summary of Cultural and Linguistic Community Referral Resources

Health Resources

Organization	Populations Served	Services	Languages Spoken*	Phone Number
Alzheimer's Association	Individuals, families, caregivers, and the community	Information and support	Spanish, French, some Asian languages	(602) 528-0545
Area Agency on Aging	Seniors and caregivers	Information and support	All	(602) 264-2255
Arizona Early Intervention Program (AzEIP)	Children 0–3 with developmental delays or disabilities	Services and resources	All	(602) -532-9960
Arizona Health Care Cost Containment System (AHCCCS)	Income-eligible individuals and families	Health care	All	(602) 417-4000
Arizona Smokers Helpline	Tobacco users	Tobacco cessation	All	1-800-556-6222
Arizona's Children Association	Children and families	Mental health services	Spanish	1-800-944-7611
Behavioral Health Services	All	Public behavioral health services information	Spanish	(602) 364-4558
Bureau of Tobacco and Chronic Disease	All	Tobacco and chronic disease information	Spanish	(602) 364-0824
Central Arizona Shelter Services	Homeless	Medical and dental clinic	Spanish	(602) 256-6945
Health Care for the Homeless	Homeless	Walk-in health clinic	Spanish	(602) 372-2100
Health-e-Arizona PLUS	All	Find health care and enroll/ re-enroll in AHCCCS	All	1-855-432-7587
Phoenix Rescue Mission	All	Substance abuse treatment (residential)	Spanish	(602) 233-3000

Shelter and Housing Resources

Organization	Populations Served	Services	Languages Spoken*	Phone Number
Andre House	Homeless	Transitional housing	Spanish	(602) 255-0580
Arizona Department of Housing	All	Support for housing, such as repairs, rental, rehabilitation, and foreclosure assistance	Spanish	(602) 771-1000
Central Arizona Shelter Services	Homeless	Shelter	Spanish	(602) 256-6945
City of Phoenix	Income-eligible residents, seniors and disabled	Housing programs	Spanish	(602) 262-4422
Phoenix Rescue Mission	Homeless	Emergency shelter and support services	Spanish	(602) 233-3000
Salvation Army – Southwest	Seniors, developmentally disabled adults and struggling families	Emergency shelter and support services	Spanish	(602) 267-4122
U.S. Department of Housing and Urban Development	All	Information and referrals for housing assistance	All	(602) 379-7100

(continued)

*In addition to English.

Health Net Access™

Summary of Cultural and Linguistic Community Referral Resources

Nutrition Resources

Organization	Populations Served	Services	Languages Spoken*	Phone Number
Central Arizona Shelter Services	Homeless	Food kitchen	Spanish	(602) 256-6945
Chandler Christian Community Center	All	Food boxes	Spanish	(480) 963-1423
Phoenix Rescue Mission	Homeless	Food kitchen	Spanish	(602) 233-3000
Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	Income-eligible children 0–5; pregnant, breastfeeding and postpartum women	Nutrition services and breastfeeding support	Spanish	(602) 506-9333

Employment and Clothing Resources

Organization	Populations Served	Services	Languages Spoken*	Phone Number
Andre House	Homeless	Employment services and clothing closet	Spanish	(602) 255-0580
Central Arizona Shelter Services	Homeless	Employment services	Spanish	(602) 256-6945
Community Kitchen	Income-eligible adults	Job training	Spanish	(602) 343-5622

Educational Resources

Organization	Populations Served	Services	Languages Spoken*	Phone Number
Head Start	Income-eligible children 0–5	Early childhood education	Spanish	(602) 506-5911

Social Support Resources

Organization	Populations Served	Services	Languages Spoken*	Phone Number
American Red Cross Grand Canyon Chapter	Victims of disaster	Resources	Spanish	(602) 336-6660
Arizona 2-1-1 Program	All	Information and referrals	All	211
Arizona Children's Association	Children and families	Adoption, foster care, kinship services, parent education, reunification	Spanish	1-800-944-7611
AZLinks	Seniors, people with disabilities, caregivers, and family members	Resources and referrals	Spanish	Website only
Birth to Five Hotline	Children 0–5 and families	Support for families with young children covering health, literacy and development	Spanish	1-877-705-5437
Department of Economic Security	All	Information and services	All	(602) 542-5065
Find Help Phoenix	All	Online tool to find support and services	Spanish	Website only

*In addition to English.

PROVIDER*Update*

CONTRACTUAL | SEPTEMBER 30, 2015 | UPDATE 15-505 | 2 PAGES

Health Net Access™

Nutritional Assessment and Nutritional Therapy Coverage and Prior Authorization Requirement Change

Arizona Health Care Cost Containment System (AHCCCS) has expanded its nutritional assessment and nutritional therapy coverage to include Health Net Access, Inc. members ages 21 and older. Additionally, the prior authorization requirement for custom orthotics has been modified for Health Net Access members, as communicated below.

NUTRITIONAL ASSESSMENT AND NUTRITIONAL THERAPY COVERAGE FOR MEMBERS AGES 21 AND OLDER

Effective October 1, 2015, nutritional assessments and nutritional therapy are a covered benefit 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.

There is no change in coverage of nutritional assessment and nutritional therapy for members under age 21 as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program when deemed necessary by the member's primary care physician (PCP). Health Net Access continues to require prior authorization for nutritional therapy on an enteral, parenteral and oral basis, and provides coverage when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member’s daily nutritional and caloric intake.

PRIOR AUTHORIZATION

In accordance with this benefit change, effective October 1, 2015, Health Net Access requires prior authorization for commercial oral nutritional supplements (medical foods) for Health Net Access members ages 21 and older. Providers must complete the prior authorization request and the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements form in its entirety and fax it directly to the Prior Authorization Department at 1-855-764-8513.

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OTH004076EW00 (9/15)

The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements form is available on the provider website at provider.healthnet.com in the Provider Library under *Forms*.

Custom Orthotics

As communicated in provider update 15-410, *Change in Coverage of Orthotic Devices for Members Ages 21 and Older*, distributed on August 7, 2015, AHCCCS expanded its coverage of orthotic devices for members ages 21 and older (under select conditions), effective August 1, 2015. In accordance with this benefit change, Health Net Access requires prior authorization for custom orthotic devices for all Health Net Access members.

ADDITIONAL INFORMATION

The Health Net Access prior authorization requirements have been revised to reflect this change and are available on the provider website at provider.healthnet.com both pre-log in and post-log in. To access them pre-log in, providers may go to *Working with Health Net > Policies for Non-Contracting Providers > Additional Resources > Services Requiring Prior Authorization*. To access them post-log in, go to *Working with Health Net > Contractual > Services Requiring Prior Authorization*.

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

PROVIDER*Update*

CONTRACTUAL | SEPTEMBER 25, 2015 | UPDATE 15-496 | 3 PAGES

Health Net Access™

ICD-10 Readiness

Effective for dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) must use the ICD-10-CM (diagnosis) code set and the ICD-10-PCS (procedure) code set when submitting claims. Health Net Access, Inc. updated its systems and processes and is prepared to process claims with ICD-10 codes.

CLAIMS SUBMISSION

Providers are required to adhere to the Centers for Medicare & Medicaid Services (CMS) guidelines and regulations according to dates of service and discharge dates. Health Net Access will deny mixed or incorrectly coded claims.

Dates of Service prior to October 1, 2015

Providers must continue to use ICD-9 codes when submitting institutional and professional claims with dates of service and discharge dates prior to October 1, 2015.

Dates of Service on or after October 1, 2015

Providers must use ICD-10 codes when submitting institutional and professional claims with dates of service or discharge dates on or after October 1, 2015.

PRIOR AUTHORIZATION

Health Net Access accepts ICD-9 codes on prior authorizations received prior to October 1, 2015, for services on or after October 1, 2015, as long as the authorization has not expired. Authorizations are valid 60 days. Providers do not need to resubmit the prior authorization request when the services rendered are within the 60-day authorization time frame.

RESOURCES

The following resources offer helpful information to assist providers in preparing for ICD-10 implementation.

CMS Website

CMS provides comprehensive information regarding ICD-10 on its website at www.cms.gov/Medicare/Coding/ICD10/index.html.

CMS Guide for ICD-10

CMS has released a concise guide about ICD-10, which highlights quick reference information and key steps for transition. The guide is available on the CMS website at www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html.

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OTH004058EH00 (9/15)

The Workgroup for Electronic Data Interchange

Health Net Access encourages providers to work with their claims vendors to prepare for ICD-10 implementation. The Workgroup for Electronic Data Interchange (WEDI) offers an online resource directory, which lists vendors that offer products and services available to assist providers in preparing for ICD-10 on its website at www.wedi.org/workgroups/icd-10/resources/2013/02/01/wedi-icd-10-vendor-resource-directory.

CMS MLN Matters SE1408 Publication

Health Net Access processes claims in accordance with the CMS MLN Matters SE1408 publication, available online at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf.

Frequently Asked Questions

Attached is a list of frequently asked questions (FAQs) offering guidance for providers and information about how Health Net Access prepared for this mandate.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

Provider-Relevant Articles Online

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Frequently Asked Questions (FAQs)

Health Net Access's Plans for ICD-10 Implementation

1. **Q: What is Health Net Access's primary strategy for ICD-9 and ICD-10 claims processing after the ICD-10 implementation date?**
   A: Health Net Access will process ICD-10 claims based on, including, but not limited to, Centers for Medicare & Medicaid Services (CMS) guidelines and regulations according to dates of service and discharge dates. This translates to Health Net Access accepting ICD-10 claims with dates of service and discharge dates on and after October 1, 2015, and ICD-9 claims received after October 1, 2015, with dates of service and discharge dates prior to October 1, 2015.

2. **Q: Is Health Net Access planning to accept ICD-9 after the compliance date?**
   A: Health Net Access will only accept claims with ICD-9 codes received after October 1, 2015, with dates of service and discharge dates prior to October 1, 2015, according to the HIPAA ICD-10 final rule mandate.

3. **Q: Is Health Net Access planning to accept ICD-10 before the compliance date?**
   A: No. Health Net Access will only accept ICD-10 claims with dates of service and discharge dates on and after October 1, 2015.

4. **Q: How long will Health Net Access provide support for both ICD-9 and ICD-10?**
   A: Health Net Access will remain compliant with existing *Provider Participation Agreement* (*PPA*) language, and state, federal and regulatory requirements related to claims processing timelines.

5. **Q: What are Health Net Access's processing guidelines for paper claims on and after October 1, 2015?**
   A: The use of the ICD-10 code sets is **not** predicated on how the claim is submitted. Paper claims will be subject to the same rules as electronic claims, in accordance with CMS guidelines.

6. **Q: Does Health Net Access have plans to update its medical policies to be consistent with ICD-10 prior to the implementation date?**
   A: Health Net Access will update all medical policies in accordance with ICD-10 coding, as needed, and communicate these changes to providers prior to the ICD-10 implementation date of October 1, 2015.

7. **Q: Will Health Net Access require or support interim billing?**
   A: Providers with inpatient members admitted prior to October 1, 2015, and discharged after October 1, 2015, need to submit the final interim bill using ICD-10 codes.

8. **Q: What if a bill is received with mixed ICD-9 and ICD-10 codes?**
   A: Health Net Access will not accept claims with mixed ICD-9 and ICD-10 coding.

9. **Q: How does Health Net Access intend to handle prior authorizations surrounding the transition date?**
   A: ICD-9 codes must be used for authorizations with dates of service prior to October 1, 2015. ICD-10 codes must be used for authorizations with dates of service on or after October 1, 2015. ICD-9 codes on prior authorizations received prior to October 1, 2015, for services on or after October 1, 2015 are accepted. Authorizations are valid 60 days. Providers do not need to resubmit the prior authorization request when the services rendered are within the 60-day authorization time frame.

PROVIDER*Update*

NEWS & ANNOUCEMENTS | SEPTEMBER 24, 2015 | UPDATE 15-473 | 3 PAGES

Health Net Access™

Cultural and Linguistic Community Referral Resources

In accordance with the Arizona Health Care Cost Containment System (AHCCCS) Contractor Operations Manual (ACOM) Chapter 400, 405 Cultural Competency and Family/Patient Centered Care, health plans are required to assess community health assets and provide cultural and linguistic community referral resources for all participating providers.

To comply with this regulation and assist providers in offering services specific to the culturally and linguistically diverse populations in their service area, Health Net Access, Inc. has created the Cultural and Linguistic Community Referral Resources contact sheets. A summary of these resources is attached for reference. Participating providers can download a comprehensive list of resources with contact information through the Health Net Access Provider Operations Manual located on the Health Net provider portal at provider.healthnet.com under *Working with Health Net > Contractual > Go to the Provider Library.* Once in the Provider Library, select *Operations Manuals > Quality Improvement > Cultural and Linguistic Services*.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

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Summary of Cultural and Linguistic Community Referral Resources

Health Resources

Organization	Populations Served	Services	Languages Spoken*	Phone Number
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Area Agency on Aging	Seniors and caregivers	Information and support	All	(602) 264-2255
Arizona Early Intervention Program (AzEIP)	Children 0–3 with developmental delays or disabilities	Services and resources	All	(602) -532-9960
Arizona Health Care Cost Containment System (AHCCCS)	Income-eligible individuals and families	Health care	All	(602) 417-4000
Arizona Smokers Helpline	Tobacco users	Tobacco cessation	All	1-800-556-6222
Arizona's Children Association	Children and families	Mental health services	Spanish	1-800-944-7611
Behavioral Health Services	All	Public behavioral health services information	Spanish	(602) 364-4558
Bureau of Tobacco and Chronic Disease	All	Tobacco and chronic disease information	Spanish	(602) 364-0824
Central Arizona Shelter Services	Homeless	Medical and dental clinic	Spanish	(602) 256-6945
Health Care for the Homeless	Homeless	Walk-in health clinic	Spanish	(602) 372-2100
Health-e-Arizona PLUS	All	Find health care and enroll/ re-enroll in AHCCCS	All	1-855-432-7587
Phoenix Rescue Mission	All	Substance abuse treatment (residential)	Spanish	(602) 233-3000

Shelter and Housing Resources

Organization	Populations Served	Services	Languages Spoken*	Phone Number
Andre House	Homeless	Transitional housing	Spanish	(602) 255-0580
Arizona Department of Housing	All	Support for housing, such as repairs, rental, rehabilitation, and foreclosure assistance	Spanish	(602) 771-1000
Central Arizona Shelter Services	Homeless	Shelter	Spanish	(602) 256-6945
City of Phoenix	Income-eligible residents, seniors and disabled	Housing programs	Spanish	(602) 262-4422
Phoenix Rescue Mission	Homeless	Emergency shelter and support services	Spanish	(602) 233-3000
Salvation Army – Southwest	Seniors, developmentally disabled adults and struggling families	Emergency shelter and support services	Spanish	(602) 267-4122
U.S. Department of Housing and Urban Development	All	Information and referrals for housing assistance	All	(602) 379-7100

*In addition to English.

Summary of Cultural and Linguistic Community Referral Resources

Nutrition Resources

Organization	Populations Served	Services	Languages Spoken*	Phone Number
Central Arizona Shelter Services	Homeless	Food kitchen	Spanish	(602) 256-6945
Chandler Christian Community Center	All	Food boxes	Spanish	(480) 963-1423
Phoenix Rescue Mission	Homeless	Food kitchen	Spanish	(602) 233-3000
Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	Income-eligible children 0–5; pregnant, breastfeeding and postpartum women	Nutrition services and breastfeeding support	Spanish	(602) 506-9333

Employment and Clothing Resources

Organization	Populations Served	Services	Languages Spoken*	Phone Number
Andre House	Homeless	Employment services and clothing closet	Spanish	(602) 255-0580
Central Arizona Shelter Services	Homeless	Employment services	Spanish	(602) 256-6945
Community Kitchen	Income-eligible adults	Job training	Spanish	(602) 343-5622

Educational Resources

Organization	Populations Served	Services	Languages Spoken*	Phone Number
Head Start	Income-eligible children 0–5	Early childhood education	Spanish	(602) 506-5911

Social Support Resources

Organization	Populations Served	Services	Languages Spoken*	Phone Number
American Red Cross Grand Canyon Chapter	Victims of disaster	Resources	Spanish	(602) 336-6660
Arizona 2-1-1 Program	All	Information and referrals	All	211
Arizona Children's Association	Children and families	Adoption, foster care, kinship services, parent education, reunification	Spanish	1-800-944-7611
AZLinks	Seniors, people with disabilities, caregivers, and family members	Resources and referrals	Spanish	Website only
Birth to Five Hotline	Children 0–5 and families	Support for families with young children covering health, literacy and development	Spanish	1-877-705-5437
Department of Economic Security	All	Information and services	All	(602) 542-5065
Find Help Phoenix	All	Online tool to find support and services	Spanish	Website only

*In addition to English.

PROVIDER*Update*

NEWS & ANNOUNCEMENTS | SEPTEMBER 21, 2015 | UPDATE 15-489 | 2 PAGES

Health Net Access™

Claims Processing and Resolution Provider Survey

Arizona Health Care Cost Containment System (AHCCCS) is conducting a survey regarding provider satisfaction with claims processing and resolution by AHCCCS contracting health plans. Health Net Access, Inc. is assisting AHCCCS in notifying providers of this survey, as providers' feedback is critical to assess and improve current processes. Attached is AHCCCS's memo regarding the survey.

Providers are encouraged to complete this brief survey online and indicate their contracting relationship, if any, with each plan listed. To access the survey, visit www.surveymonkey.com/r/AHCCCSProviderClaimsSurvey2015.

ADDITIONAL INFORMATION

Providers may access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

Provider-Relevant Articles Online

Access informative Online News articles today by logging in to provider.healthnet.com. Select the rotating graphic to read or print articles of interest. Health Net posts new articles each week that cover a variety of topics, such as administrative procedure reminders, quality improvement tips and health care initiatives.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- Physicians
- Medical Groups/IPAs
- Hospitals
- Ancillary Providers

PROVIDER SERVICES

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PROVIDER DISPUTES

Health Net Access Provider Disputes
1230 W Washington Street, Ste. 401
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STATE FAIR HEARINGS

Health Net Access Provider State Fair Hearings
1230 W Washington Street, Ste. 401
Tempe, AZ 85281

NATIONAL PROVIDER COMMUNICATIONS

provider.communications@healthnet.com
fax 1-800-937-6086

DATE: September 21, 2015

TO: AHCCCS Managed Care Providers

FROM: AHCCCS, Division of Healthcare Management - Operations

SUBJECT: Provider Survey Regarding Claims and Resolution

AHCCCS is conducting a survey to ascertain providers' level of satisfaction with Claims Processing and Resolution by its contracted Health Plans. Your feedback is very important to our assessment and processes for improvement.

Please take a few minutes to complete this brief survey and be sure to indicate if you are contracted with each listed Plan. The survey can be accessed at the following link: https://www.surveymonkey.com/r/AHCCCSProviderClaimsSurvey2015.

Thank you in advance for your valuable feedback.

AHCCCS, Division of Health Care Management – Operations

PROVIDER*Update*

CONTRACTUAL | SEPTEMBER 10, 2015 | UPDATE 15-472 | 3 PAGES

Health Net Access™

Interpreter Services and Cultural Training

Health Net Access, Inc. offers participating physicians, medical groups, ancillary providers, and members 24-hour access to telephonic interpreter services. Additionally, Health Net Access offers in-person interpreter services, as well as sign language assistance, during business hours at no cost. These services feature the following:

- qualified interpreters trained on health care terminology and a wide range of interpreting protocols and ethics
- support to address common communication challenges across cultures

This communication describes Health Net Access interpreter services and lists access information.

INTERPRETER SERVICES

Health Net Access provides interpreter support for limited-English proficient (LEP) members at all medical points of contact. Providers are asked to make accommodations to use telephone interpreters as that may be the only service available for the appointment time or language. Health Net Access recommends three to five days advance notice to schedule in-person interpreters. Telephone interpreter services do not need to be scheduled in advance of the appointment; however, providers need to allow adequate time before the appointment time to get the telephone interpreter on the line. Providers who have questions or need interpreter services may contact the Provider Services Center at 1-888-788-4408, 24 hours a day, seven days a week. In-person interpreters are available between 7:00 a.m. and 6:00 p.m., Monday through Friday. When calling, providers must have available the member's name, Health Net Access identification (ID) number, and appointment date and time, if necessary.

CULTURAL AND LINGUISTIC APPROPRIATENESS

Health Net Access provides the following to comply with mandated cultural and linguistic appropriateness standards:

- oral language services that include answering questions and providing assistance in more than 150 non-English languages
- upon request, Spanish translation of vital documents that provide information about eligibility and how to participate in the plan
- a statement indicating how to access language services in the most common non-English languages spoken in Arizona

PROVIDER RESPONSIBILITIES

Participating providers may use Health Net Access interpreter services to provide interpreters to members who require or request them. Participating providers must ensure that language services meet the established requirements as follows:

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- ● Physicians
- ○ Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers
- ○

PROVIDER SERVICES

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(888) 788-4408
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 OTH003603EH00 (9/15)

- Ensure that LEP members are not subject to unreasonable delays in the delivery of services including access to providers after hours.
- Do not require or encourage members to use family members or friends as interpreters. Health Net Access strongly discourages the use of minors as interpreters, unless used in an emergency situation.
- Provide interpreter services at no cost to members.
- Extend same participation opportunities in programs and activities to all members regardless of their language preferences.
- Provide services to LEP members that are as effective as those provided to others.
- Record the language needs of each member, as well as the member's request or refusal of interpreter services, in his or her medical record.
- Advise members that they may file grievances with Health Net Access if their language needs are not met.

PROVIDERS DELEGATED FOR UTILIZATION MANAGEMENT ONLY

In addition to the above, providers delegated for utilization management (UM) must comply with the following:

- Translation services – Upon request, provide Health Net Access with the documents sent to members in a timely manner. If a Health Net Access member requests translation of an English document that was produced by an ancillary provider on Health Net Access' behalf, the provider must refer the member to the Health Net Customer Contact Center (CCC) telephone number listed on the member's ID card. When the Health Net Access CCC receives the member's request, Health Net contacts the provider requesting a copy of the specific English document for translation. The provider must submit the document within 48 hours of the Health Net Access request.
- Notice of Language Assistance (NOLA) – Include Health Net Access-specific NOLA, which advises members that they can receive support in their preferred language, with vital documents distributed to Health Net Access members (for example, UM denial and delay notices, and claims notices that require member action). A sample notice is available in the provider operations manuals on the Health Net provider website at provider.healthnet.com. From the Provider Library, choose the appropriate audience and product line, and select *Forms > Notice on the Availability of Language Assistance.*

CULTURAL COMPETENCY TRAINING

All Health Net Access participating providers are requested to take cultural competency training. The United States Department of Health and Human Services' Office of Minority Health (OMH) offers a computer-based training (CBT) program, *A Physician's Practical Guide to Culturally Competent Care,* on cultural competency for health care providers. The cultural competency curriculum modules (CCCMs) are available to physicians, physician assistants (PAs) and nurse practitioners (NPs), and are self-paced. They were developed to furnish providers with competencies that enable them to better treat an increasingly diverse population. This no-cost educational program is available to providers through the OMH Think Cultural Health website at https://cccm.thinkculturalhealth.hhs.gov. Health Net Access does not sponsor or maintain the OMH CBT or website.

The OMH Think Cultural Health website contains a variety of self-assessments, case studies, video vignettes, learning points, continuing medical education (CME) post-tests, and the opportunity to submit feedback and view other participants' feedback about the cases and content. It also includes links to health care community advocacy and consumer groups.

CME Credits

The Professional Education Services Group (PESG) designates the OMH CCCMs for a maximum of nine category-one CME credits toward the American Medical Association (AMA) Physician's Recognition Award. Physicians may claim credits upon completion in the activity. Additional CME information is available at https://cccm.thinkculturalhealth.hhs.gov under *Earn Credit.*

Getting Started

Providers can register online at https://cccm.thinkculturalhealth.hhs.gov to complete the OMH cultural competency educational activity. The registration process includes standard demographic questions required for all CME activities. Once registered, providers may enter their user name and password to access the site. Each time providers log in to the site, they are directed to the page where they left off on the previous visit.

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

Providers who would like information about cross-cultural communication, health literacy or accessing interpreter services may contact Health Net's C&L Services Department by email at Cultural.and.Linguistic.Services@healthnet.com or by telephone at 1-800-977-6750. For all other questions, contact the Health Net Access Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at 1-888-788-4408.

Provider-Relevant Articles Online

Access informative Online News articles today by logging in to provider.healthnet.com. Select the rotating graphic to read or print articles of interest. Health Net posts new articles each week that cover a variety of topics, such as administrative procedure reminders, quality improvement tips and health care initiatives.

Health Net Access, Inc.
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August 28, 2015

<Title>
<Address_1> <Address_2>
<City>, <State> <ZIP>

Dear <Title>:

Arizona ranks 6th highest in the nation for prescription medication misuse and abuse.[1] In collaboration with community partners across Maricopa County, Health Net Access, Inc. is participating in the Maricopa County Sign Up to Save Lives campaign. One of the campaign goals is to reduce prescription medication misuse and abuse. As part of our commitment to the Sign Up to Save Lives campaign, Health Net Access is requesting that participating providers in Maricopa County register online at pharmacypmp.az.gov and participate in the Arizona Controlled Substances Prescription Monitoring Program (CSPMP). CSPMP was developed to promote public health and welfare by detecting diversion, abuse and misuse of prescription medications classified as controlled substances under the Arizona Uniform Controlled Substances Act.

Accessing patient information from CSPMP has many benefits, including:

- Improving patient care – Pharmacy monitoring reduces the risk of drug to drug interactions and adverse outcomes in patients managed by multiple providers due to complex chronic care needs.
- Improving patient safety – Many patients may see more than one prescriber, some may not inform each provider about other medications they are taking, and some may engage in doctor shopping. CSPMP can help keep your patient safe and minimize diversion of prescription medication.
- Limiting prescriber liability – Checking patient medication history through CSPMP is a good practice to ensure standards of care are upheld and limit liability involved with dangerous medication combinations or high-dose prescribing, especially if a patient visits more than one prescriber.
- Accessing patient information easily – Prescribers can appoint an office designee to access their patients' medication histories from CSPMP, just like they do patient charts. This reduces prescriber time and helps to ensure patient safety and minimize liability concerns.

Currently, 30 percent[2] of Arizona practitioners participate in CSPMP. Health Net Access aims to increase this percentage and encourages providers to register at pharmacypmp.az.gov and begin accessing patient information through CSPMP. Enclosed is a checklist that explains the process of registering for and using CSPMP. We appreciate your time and consideration as we work together to improve patient outcomes and reduce prescription medication misuse and abuse.

Sincerely,

Rodgers M. Wilson, MD, CHCQM
Arizona Medical Director

Mary Ann Lecavalier, MD
Health Net Access Medical Director

Enclosure

[1] National Survey on Drug Use and Health 2012.
[2] Arizona State Board of Pharmacy 2014.

Registering for and Using the Controlled Substances Prescription Monitoring Program (CSPMP)	
New User Instructions	
Step 1: Register	Register for CSPMP at pharmacypmp.az.gov. Select *Register now* and complete the New Registration information.
Step 2: Verify	After submitting the registration information, a verification email with the CSPMP identification (ID) number and verification code is sent. Follow the email link to verify your email address.
Step 3: Log in	Once you log in, you will be able to complete your registration profile with your CSPMP ID and Drug Enforcement Administration (DEA) number. Fill out the Registration Details and certify that the application is complete and accurate, then select *Print Certificate*.
Accessing Patient Information	
Step 1: Register	Log in to pharmacypmp.az.gov and follow the appropriate *Accessing the data* link for medical practitioners or pharmacists. A New Registration form pops up. Complete the form and submit.
Step 2: Confirm	Once completed, your access registration will be confirmed and you will receive a user name and password via email, usually within 24 to 48 hours. Exception: If you are a provider with a nonresident medical license, you must print your access registration, read and sign the Privacy Statement, and have it notarized. Mail both documents along with a copy of your nonresident medical state license and driver's license. Once received and processed, a user name and password will be emailed to you.
Step 3: Log in	When you receive your user name and password, you will be able to log in to the CSPMP.
Requests Patient Information	
Step 1: Request	Log in to the CSPMP. Under the Request tab at the top left of the screen, select *New Request* and then complete the request form.
Step 2: Open	The requested information is sent as a PDF attachment.

PROVIDER*Update*

REGULATORY | AUGUST 26, 2015 | UPDATE 15-417 | 2 PAGES

Health Net Access™

Improving Access to Care and the Patient Experience

Health Net Access, Inc. is committed to monitoring members' access to providers who meet members' care needs, including timeliness standards for wait times for routine appointments, urgent care appointments and urgent care. Providers should use the guidelines below to ensure compliance with appointment accessibility standards for members, in addition to the recommendations to improve access to care and patients' experience.

Improving access to care, coordination of care and access to resources results in better patient experiences. Implementing such improvements can help improve outcomes through a reduction in:

- no-show appointments
- emergency room (ER) visits
- patients leaving against medical advice (AMA) from inpatient and ER settings
- hospital readmissions
- complaints, appeals, grievances, and quality of care concerns

AHCCCS APPOINTMENT ACCESS STANDARDS

The table below includes appointment accessibility standards established by the Arizona Health Care Cost Containment System (AHCCCS) for which providers must comply for primary care and specialist appointments.

Primary Care and Specialist Appointment Standards

	ROUTINE	URGENT	EMERGENCY
PRIMARY CARE	21 days	2 days	Within 24 hours
SPECIALIST	45 days	3 days	Within 24 hours

RECOMMENDATIONS FOR IMPROVING ACCESS TO CARE

The following recommendations may help providers improve access to care and the patient experience for members.

- Enhance communication and coordination among members, specialists and behavioral health providers. Be sure to share pertinent treatment information with the patients' specialty care providers[1], including behavioral health providers (such as medications prescribed by other physicians).
- Assist members with transportation needs. Provide members with the Health Net Access Customer Contact Center number (1-888-788-4408) to arrange transportation in advance of the member's appointment date.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- Physicians
- Medical Groups/IPAs
- Hospitals
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- If it appears that a member needs assistance with his or her medical needs or care coordination, providers can refer him or her to Health Net Access Case Management. The Health Net Access Case Management Referral Form, available online in the *Forms* section of the Provider Library at provider.healthnet.com, can be completed and submitted via email to CMAccess/GRP/HNCA/HNT@FHS, or by fax to 1-800-956-0721 or 1-855-825-6146.
- Providers are strongly encouraged to use electronic prescribing (e-prescribing), which provides many potential benefits for providers' practices and patients, including improved management of time and workflow efficiency, compliance with regulatory requirements, and improved patient satisfaction in the office and at the pharmacy. For more information and resources about e-prescribing, refer to the *Clinician's Guide to e-Prescribing: 2011 Update* from the American College of Physicians℠ website at www.acponline.org/running_practice/technology/eprescribing/, or visit the Surescripts website at http://surescripts.com.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

[1] The Health Insurance Portability and Accountability Act (HIPAA) permits the exchange of information for the purposes of treatment, payment and health care operations. In the event that information is exchanged between providers, it is the provider's option to inform the patient of the exchange. This includes exchanges of medical record information between physicians and specialists.

Update your info online

Is your demographic information current for Health Net provider directories and the online ProviderSearch function? Submit updates and corrections, including information regarding practice locations, provider names, languages spoken at the practice, and office hours, on the provider website at provider.healthnet.com by selecting *My Account > Update Provider Information*.

PROVIDER*Update*

REGULATORY | AUGUST 7, 2015 | UPDATE 15-410 | 1 PAGE

Health Net Access™

Change in Coverage of Orthotic Devices for Members Ages 21 and Older

Arizona Health Care Cost Containment System (AHCCCS) has expanded its coverage of orthotic devices for members who are ages 21 and older. Effective August 1, 2015, orthotic devices are a covered benefit for Health Net Access, Inc. 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.

There is no change in coverage of orthotic devices for members under age 21. Health Net Access continues to cover orthotic devices when they are medically necessary and the orthotics cost less than other treatments that are as helpful for the condition.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

Discover Helpful Tools to Support Your Office

The Provider Library online at provider.healthnet.com allows participating providers to quickly access pertinent information to assist in their everyday interaction with Health Net. The Provider Library includes operations manuals, communications (updates and letters), Online News articles, forms, Health Net contact information, and more.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- ● Physicians
- ○ Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

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PROVIDER*Update*

CONTRACTUAL | AUGUST 7, 2015 | UPDATE 15-403 | 1 PAGE

Health Net Access™

Decision Power® and Case Management Referral Fax Forms

The Decision Power®[1] Referral to Health Net Fax Form has been updated to include comprehensive information on all Health Net Access, Inc. Decision Power program options. Additionally, the Case Management Referral Fax Form is available for providers' case management referral needs.

DECISION POWER

Health Net's Decision Power program provides fully integrated, health management solutions to improve the health and quality of life of Health Net members. Through personalized interventions and contemporary behavior change methodologies, experienced, specially trained clinical professionals with the program can assist members who are at-risk and diagnosed with chronic health conditions to better manage their conditions through education, empowerment and support. 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 health conditions.

COMPLEX CASE MANAGEMENT

Health Net's case management program targets members with 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 members, their families and caregivers. These members often have multiple comorbid conditions and need assistance in planning, managing and executing their care.

ACCESSING REFERRAL FORMS

The Decision Power Referral to Health Net Fax Form and Case Management Referral Fax Form are available in the Provider Library on the Health Net provider website at provider.healthnet.com under *Forms*.

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

[1] Health Net members have access to Decision Power through their current enrollment with Health Net Access, Inc. Decision Power is not part of Health Net's commercial medical benefit plans. Also, it is not 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. But 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.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- Physicians
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PROVIDER*Update*

NEWS & ANNOUNCEMENTS | AUGUST 6, 2015 | UPDATE 15-396sum | 2 PAGES

Health Net Access™

Summary Update: Quality Management Program

This communication provides a summary of the components of the Health Net Access, Inc. multifaceted quality management (QM) program, including its quality and process improvement (QI/PI) activities and instructions on how to obtain additional information about the program. Providers are encouraged to review the complete description of the Health Net Access QI program at least annually to be familiar with the programs and resources available to assist in improving members' health.

OVERVIEW

The Health Net Access 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 and systematic basis. The QM program also supports the identification and pursuit of opportunities to improve health outcomes and satisfaction. The program includes the development and implementation of standards for clinical care and service, the measurement of adherence to the standards and the implementation of actions to improve performance. Standards include, but are not limited to the following:

- clinical practice guidelines
- medical management/utilization management
- maternal-child health (MCH)/Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- complex case management
- preventive health guidelines
- pharmaceutical management
- provider accessibility standards
- member rights and responsibilities
- medical record documentation

More extensive information about all the programs listed in this summary update is available on the Health Net provider website at provider.healthnet.com. Additional information located online includes:

- member appeals
- utilization management process, authorization of care and criteria
- use of protected health information (PHI)

ADDITIONAL INFORMATION

A complete overview of the components of the quality management program is available in provider update 15-396*, Quality Management Program*, available in the Provider Library on the provider website at provider.healthnet.com under *Updates and Letters* >

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- Physicians
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OTH002150EW00 (8/15)

2015. Providers who do not have access to the Internet may request printed copies of provider materials by contacting the Health Net Access Provider Services Center. More extensive program descriptions are also contained within the provider operations manuals online in the Provider Library.

Providers can visit the QI Corner on the provider website at provider.healthnet.com under *Working with Health Net > Quality > Quality Improvement Corner* to view Health Net Access quality outcomes and progress towards goals. The QI Corner also contains tools and materials that can assist providers in delivering care that upholds the standards and performance that members expect.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the provider website at provider.healthnet.com, or by telephone at 1-888-788-4408.

Update Your Info Online

Is your demographic information current for Health Net provider directories and the online ProviderSearch function? Submit updates and corrections, including information regarding practice locations, provider names, languages spoken at the practice, and office hours, on the provider website at provider.healthnet.com by selecting *My Account > Update Provider Information*.

PROVIDER*Update*

NEWS & ANNOUNCEMENTS | AUGUST 6, 2015 | UPDATE 15-396 | 11 PAGES

Health Net Access™

Quality Management Program

This communication provides an overview of the components of the Health Net Access, Inc. multifaceted quality management (QM) program, including its quality and process improvement (QI/PI) activities and instructions on how to obtain additional information about the program. Health Net Access develops an annual QM program work plan addressing all requirements of the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency. Providers are encouraged to review the complete description of the QM program at least annually to be familiar with the programs and resources available to assist in improving members' health. For the most current and accurate information, Health Net Access recommends that providers regularly visit the Health Net provider website at provider.healthnet.com. A complete copy of the Health Net Access QM program description and overall progress toward meeting QM goals is available upon request from the Health Net Access QM Department via email at AHCCCS_Notification@healthnet.com.

OVERVIEW

The Health Net Access 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 and systematic basis. The QM program also supports the identification and pursuit of opportunities to improve health outcomes and satisfaction. The program includes the development and implementation of standards for clinical care and service, the measurement of adherence to the standards and the implementation of actions to improve performance. Standards include, but are not limited to the following:

- clinical practice guidelines
- medical management/utilization management
- maternal-child health (MCH)/Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- complex case management
- preventive health guidelines
- pharmaceutical management
- provider accessibility standards
- member rights and responsibilities
- medical record documentation

OPEN CLINICAL DIALOGUE

Health Net Access providers are encouraged to communicate freely with members regarding their medical conditions and treatment alternatives, including medication treatment options, regardless of coverage limitations. In addition, Health Net strongly recommends communication between primary care physicians (PCPs) and behavioral health specialists to ensure members' safety and continuity of care.

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WHOLE-PERSON STRATEGY

Through Health Net's suite of clinical and wellness programs, Health Net Access unifies programs, from wellness to complex care, reflecting Health Net Access' commitment to a whole-person strategy. Members may access wellness programs related to obesity prevention, smoking cessation, pregnancy support, asthma, diabetes, and disease management for heart failure (HF), chronic obstructive pulmonary disease (COPD), and coronary artery disease (CAD) by logging in to the Health Net Access member website at www.healthnet.com.

Clinical and Wellness Programs

The Health Net Access clinical and wellness programs provide a fully integrated, health management solution aimed to improve the health and quality of life for Health Net Access members. Through personalized interventions and contemporary behavior change methodologies, Health Net's experienced clinical staff can assist members who are at risk and diagnosed with chronic health conditions to better manage their conditions through education, empowerment and support. This suite of programs includes end-to-end clinical management that encompasses health and wellness, disease management, case management, and women and children's health.

The electronic data platform provides users with flexible technology that integrates all data regarding a member's wellness, chronic disease and maternity. It also integrates data from point-of-care devices into clinical workflows creating a complete view of a member's current and past health. The integrated care system provides a complete member profile allowing timely and actionable identification of gaps in care, and the opportunity to effectively reduce delays in care that often result in poor health outcomes. Additionally, registered medical groups have access to the integrated care system through the Provider Activity Dashboard (PAD). Using the PAD, providers can view their patient's Health Risk Questionnaire (HRQ) results, case management or disease management status, and any alerts related to medication adherence and usage or gaps in care. Member information and reports are offered in a secure environment to allow for more continuous and coordinated care. Providers may request PAD access or training via email to Janet Lynn at janet.x.lynn@healthnet.com.

Wellness Discount Programs

Health Net Access offers discounts on programs and resources to help members adopt and maintain healthy lifestyles, such as:

- exclusive discounts on weight loss programs, vitamins, herbs and supplements, health clubs, and other health-related products and services, including discounts with Jenny Craig® and Weight Watchers®
- tools to monitor prescription history and check medication interactions; estimate cost of care for more than 100 conditions, 50 procedures or surgeries, and 200 medical tests or visits; compare hospital performance on more than 160 common diagnoses and procedures; and help members understand their health plan options, so that they can choose the plans that best fit their families

DISEASE MANAGEMENT

The Health Net Access disease management program provides support to members with chronic conditions, including HF, COPD, CAD, diabetes, and asthma. Through this program, Health Net Access can help to increase the efficiency and effectiveness of care, which leads to more timely action by members and helps develop more personalized and actionable solutions that ultimately improve 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 (ER) visits, hospitalization and medication errors, and prevent future occurrences

COMPLEX CASE MANAGEMENT

The Health Net Access complex case management program targets the most complex cases, often with life-limiting diagnoses, and assists members who have critical barriers to their care. Trained nurse case managers provide 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.

Health Net Access complex case management programs include intensive, face-to-face contact, as needed, between care managers and Health Net Access members who have multiple comorbid conditions. This individualized approach helps support members' complex treatment plans and targets the most medically complex cases. Once a Health Net Access member is selected to participate in the program, a care manager from Health Net Access contacts the member's physician and works closely with that physician to coordinate care for the member.

Referral Guidelines

Health Net Access conducts daily utilization surveillance to identify appropriate members for this program; however, providers may also become aware of a severely ill Health Net Access member not currently enrolled in this program who may benefit from complex case management services. Providers should use the criteria below when considering whether to refer a member to the Health Net Access complex case management program.

The program's target population is comprised of patients with one or more of the following:

- significantly poor diagnoses, such as advanced cancer and end-stage diseases, including HF, COPD and multiple sclerosis
- significant symptoms, such as disease-related pain, dyspnea, fatigue, nausea, constipation, and depression
- multiple care providers that may not be communicating with each other, which increases the risk of an acute event, such as hospital readmission
- complex psychosocial issues, including:
  - inadequate support system and caregiver burnout
  - unsafe environment
  - significant financial issues

Providers should consider the below questions to determine whether the member has one or more of the following issues that cannot be managed by the provider's office or treating specialists:

- Does the member have a terminal diagnosis or prognosis and struggle with whether to proceed with aggressive or palliative treatment?
- Is the member experiencing significant problems due to disease-related pain and symptom control, such as fatigue, anxiety, nausea, constipation, dyspnea, or depression?
- Does the member live in an unsafe environment?
- Does the member have significant financial issues?
- Does the member have multiple providers of care that may not be communicating, which creates an ongoing risk for an acute event, such as readmission?
- Has the member developed severe, complicated comorbidities?
- Does the member have an inadequate support system or is the primary caregiver suffering from burnout?

If a Health Net Access member meets any of these criteria, providers may contact the Case Management Department at 1-800- 977-7281. Members who want to self-refer into this program may call the toll-free Member Services number on the back of their Health Net Access identification (ID) cards. The Member Services representative contacts the Case Management Department with the member's information for appropriate outreach. Contacting the Case Management Department does not automatically qualify the member for the Health Net Access complex case management program.

CareAlerts for Members and Providers

The CareAlerts program applies predictive modeling algorithms to identify clinical gaps in care, medication interactions and dangerous medication side-effects across the member population. Results identify actionable opportunities to improve quality of care and address medication safety for specific individuals.

The CareAlerts program promotes physician-patient relationships and encourages Health Net Access members to share the information included in the CareAlerts with their providers to discuss how to better manage members' health. The goal is to improve member treatment plan compliance and care coordination for clinical and quality outcomes.

The data-driven CareAlerts program includes pharmacy, medical, laboratory, and other claims data, and identifies several patient-specific care gaps within the following four categories. These care gap categories were developed based on

national guidelines, Healthcare Effectiveness Data and Information Set (HEDIS®[1]) measures, and evidence-based health management and prevention recommendations:

- Prevention – screening tests, immunizations and follow-up visits.
- Care gaps – suboptimal therapies for chronic conditions, such as appropriate pharmacological therapies or biometric monitoring goals.
- Medication therapy – age-appropriate therapy; some medications have a higher risk for the elderly.
- Prescription adherence and safety – medication and disease interactions, medication adherence or early discontinuation of maintenance medications, or duplicate therapies.

Technology and content management, along with a suite of proprietary business rules, determine the following for each patient-specific care gap result:

- message recipient
- communication mode
- message content
- optimal timing for communication using message prioritization rules
- message frequency

Healthy Pregnancy Program

The Healthy Pregnancy program is available to Health Net Access members and provides a range of resources during pregnancy. The program provides resources to educate women and screen for high-risk pregnancies. Additionally, the program underscores the importance of perinatal care and the patient-provider relationship while providing patients with access to additional support and educational resources. The program includes the following elements:

- Access to BabyLine® – Members enrolled in the Healthy Pregnancy program have access to Health Net's pregnancy telephone line up to six weeks following the birth of their babies. The line is staffed with experienced perinatal nurses who are available 24 hours a day, seven days a week.
- Obstetric (OB) risk assessment and education – Components of this program include initial assessment to identify members with high-risk obstetrical conditions; follow-up assessment completed at approximately 28 weeks; and outcomes assessment conducted post-delivery.
- OB case management – This program offers the experience of high-risk OB nurse case managers who are available 24 hours a day, seven days a week. OB case management has been shown to prolong pregnancies, improve birth weights and minimize hospitalizations. A high-risk OB nurse case manager is assigned to each member with high-risk obstetrical conditions to create a unique care plan with goals, support, target dates, and periodic assessments, and maintains regular contact with the member through Health Net's high-risk nurse outreach component.

Neonatal Intensive Care Unit

The Health Net Access care management program manages newborn infants who are in the neonatal intensive care unit (NICU). The goal of this program is to improve outcomes for infants admitted to the NICU or other specialty care unit, providing on-site case and utilization management. Other program highlights include:

- weekly reviews and follow-up 14 days after discharge
- family involvement and education
- discharge planning
- reduced lengths of stay and readmissions

Nurse24℠

Nurse24℠ (N24) is a telephonic support program that empowers members to better manage their health. N24 offers support for members coping with chronic and acute illness, episodic or injury-related events, and other health care issues. Highly trained registered nurses are available 24 hours a day, seven days a week to monitor and process health care inquiries that help members make informed health care decisions.

N24 staff are trained in telephone triage, and the health information manager may help members navigate through questions and concerns about symptoms, appropriate treatment choices, comorbid conditions, and additional risk factors. Utilizing an accredited knowledge base of more than 5,500 health topics, the nurses have additional tools to address triage calls effectively and appropriately. The N24 team also refers members to additional programs that include, but are not limited to, disease management, maternity and case management programs.

N24 program highlights include:

- chat capability from the member portal with N24 clinicians
- health information managers with experience in discovering health problems and who are trained in telephone triage
- improved continuity of care through integration with disease management services
- help to reduce excessive or unnecessary ER visits
- access to nationally recognized Healthwise® Knowledgebase that offers information on more than 5,500 health topics

AMBULATORY CASE MANAGEMENT

Health Net Access offers ambulatory case management to high-risk members with less complex needs using an advanced analytical model. The initial assessment is conducted over the telephone with a follow-up contact every other week. A medical director is involved in every case and cases are reviewed monthly or more frequently as needed. The average duration of case management engagement is one to three months. During the program, the assigned case manager thoroughly documents and strictly adheres to program follow-up schedules, comorbid assessment and interventions. In addition, intensive medical director participation in care plan development and execution is provided.

ARIZONA PALLIATIVE HOME CARE

Health Net Access has partnered with Arizona Palliative Home Care (AzPHC) to help manage care for seriously ill members, providing critical in-home services and helping reduce the likelihood of hospital readmission. The goal of the program is to increase the function and quality of life for the member.

The program offers concurrent and collaborative care with the member's PCP. Services include home visits from a physician or nurse practitioner, home visits from a nurse or social worker to coordinate care, assistance with personal care, and pain management consultation. AzPHC staff provide ongoing updates on in-home visits and findings to the member's PCP. Services through AzPHC are available 24 hours a day, seven days a week.

PEDIATRIC AND ADOLESCENT OVERWEIGHT ASSESSMENT AND MANAGEMENT GUIDELINES

In an effort to support busy providers with resources to care for children and adolescents at risk for overweight and obesity, Health Net Access offers the *Pediatric and Adolescent Overweight Assessment and Management Guidelines* flip chart. This chart gives providers practical, point-of-care guidance on the prevention and treatment of overweight and obesity. Adapted from the *Child and Adolescent Obesity Provider Toolkit* produced by the California Medical Association (CMA) Foundation and an expert panel of health care professionals, Health Net Access created this flip chart to offer the latest tools and practice recommendations for providers in addressing overweight and obesity in their patients, including:

- identification and management of body weight with routine calculation of body mass index (BMI)
- assessment, monitoring and management of at-risk children and adolescents, including brief education and counseling tools, targeted laboratory screenings and appropriate specialty referrals
- cultural sensitivity considerations during the patient-provider experience
- resource information for nutrition, physical fitness and life-skill support education, national guidelines, and weight management programs

To review the electronic version of the complete *Child and Adolescent Obesity Provider Toolkit*, visit the CMA Foundation website at www.thecmafoundation.org/programs/obesity. To obtain a copy of the *Pediatric and Adolescent Overweight Assessment and Management Guidelines* flip chart, providers may contact the Health Education Department at 1-800-804-6074.

T2X

T2X is a free, social media website targeted toward teenagers and adults and developed in partnership with the University of California – Los Angeles (UCLA) Fielding School of Public Health and EPG Technologies, Inc. T2X offers professionally

produced educational programs, games, quizzes, blogs, video sharing, and other interactive and participatory communication methods. The site educates and motivates participants to take healthier approaches toward important lifestyle issues, such as nutrition, fitness, stress management, substance abuse, and sexual health.

The goal of T2X is to increase participants' capacity to access and appropriately use their insurance, become more engaged in their health care and health behavior decisions, and develop pro-health attitudes. All participants ages 13 and older, regardless of health insurance status, can join for free online at www.t2x.me.

ARIZONA SMOKER'S HELPLINE

Smoking cessation support is available for Health Net Access members through the Arizona Smoker's helpline at 1-800-556-6222, or online at www.ashline.org. Upon referral, members receive free help to quit tobacco use, which includes:

- telephone-based coaching
- online self-paced quit program
- medication assistance

Medication assistance is available to helpline participants. Participants are eligible to receive two free weeks of nicotine patches, gum or lozenges mailed directly to their residence. Providers may request referral forms by contacting the Health Net Access QI Department at AHCCCS_Notification@healthnet.com.

CLINICAL PRACTICE GUIDELINES

Health Net Access evidence-based clinical practice guidelines are updated annually and when new scientific evidence or national standards are published. Health Net's Medical Advisory Council (MAC) adopts the clinical practice guidelines, including preventive health services, which are available on the provider website at provider.healthnet.com under *Working with Health Net > Clinical > Medical Policies*. Providers who do not have access to the Internet may contact the Health Net Access Provider Services Center to request printed copies of these guidelines.

EPSDT PROGRAM

The EPSDT program is a comprehensive child health program of prevention, treatment, correction, and improvement (or amelioration) of physical and behavioral/mental health conditions 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 under federal law.

EPSDT tracking forms must be used by providers to document all age-specific, required information related to EPSDT screenings and visits. EPSDT services must be provided according to community standards of practice and the AHCCCS EPSDT and Dental Periodicity Schedules. Health Net Access has policies and procedures to monitor, evaluate and improve EPSDT participation by PCPs. For more information about the EPSDT program and tracking forms, contact the Health Net Access Maternal-Child Health/EPSDT team at AZ_EPSDT_MCH@healthnet.com.

UTILIZATION MANAGEMENT PROGRAM

Health Net Access uses utilization management (UM) decision-making criteria that are objective and based on medical evidence to determine medical necessity, including InterQual®, Hayes Medical Technology Directory, National Medical Advisory Council Statements, and Health Net Access medical policies.

Health Net Access medical policies are available to providers on the provider website at provider.healthnet.com. Copies of specific Health Net Access criteria are also available upon request by contacting the Health Net Access Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the provider website at provider.healthnet.com, or by telephone at 1-888-788-4408.

When a medical necessity decision results in a denial, the denial criteria are identified in the denial letter. Each denial letter explains how to obtain a copy of the criteria, a statement on the Health Net Access appeal process, and the name and telephone number of the Health Net provider reviewer who is available to discuss denial decisions with the requesting provider, as required. Health Net Access UM staff are available by contacting Health Net Access Provider Services.

UM decisions are based only on appropriateness of care, service and existence of coverage. Health Net Access does not reward providers for issuing denials of coverage for health care or services. There are no financial incentives for UM decision-makers to encourage decisions that result in under-utilization.

QUALITY IMPROVEMENT INITIATIVES

Health Net Access participates in quality and performance improvement projects initiated by AHCCCS on topics that take into account comprehensive aspects of members' needs, care and services. In addition, Health Net Access may select and design, with AHCCCS approval, additional performance improvement projects that are specific to members' needs and are identified through internal monitoring of data for trends. Members may receive mailings or interactive voice response (IVR) calls providing them with important educational information and reminders to take action when necessary. For more information about the initiatives available, contact the Health Net Access QI Department via email at AHCCCS_Notification@healthnet.com.

QUALITY MEASURES AND SURVEYS

Health Net Access measures the quality of care and services provided to members in a number of ways, including, but not limited to, HEDIS-like performance measures for care and service. Health Net Access also monitors and tracks the minimum performance standards established by AHCCCS, and strives to meet performance measure outcomes and goals from year to year.

QUALITY AND SAFETY REPORTING

Health Net Access maintains the Hospital Advisor Tool, which includes performance metrics by diagnosis or procedure, such as volume, cost, mortality, and complications. The report also includes safety information from The Leapfrog Group and CMS' Hospital Quality Initiative. This Web-based tool is available to members and providers to support informed decisions when seeking care. In addition, Health Net Access reports performance metrics pertaining to the quality and safety of member care according to AHCCCS regulations.

BEHAVIORAL HEALTH SERVICES

As appropriate, PCPs provide care for Health Net Access members who have been diagnosed with depression, postpartum depression, anxiety, and attention deficit hyperactivity disorder (ADHD). In addition, upon referral by a PCP or at a member's initiative, specialty behavioral health services can be obtained through the Regional Behavioral Health Authority (RBHA).

Coordination of care is fundamental to the member's well-being. PCP offices that receive information from other medical or behavioral health specialists are encouraged to document the information in the member's medical record and review relevant information with the member at his or her next primary care visit. In addition, PCPs are strongly encouraged to create a comprehensive medical record with a behavioral health section and provide the member's behavioral health provider with information about the member's medical conditions that could affect their mental health.

Screening for Behavioral Health Conditions

Providers are encouraged to screen members for depression and other behavioral health conditions. Various brief screening instruments are available, such as the Patient Health Questionnaire (PHQ-9) from the MacArthur Initiative on Depression and Primary Care at www.depression-primarycare.org. Other useful resources for assessing, monitoring and treating depression-like symptoms are available via the *Health Net–MHN Depression Clinical Practice Guidelines* on the provider website at provider.healthnet.com. In addition, the following AHCCCS clinical toolkits are available in the provider operations manuals on the provider website in the Provider Library:

- Children – ADHD, anxiety and depression toolkits
- Adults – ADHD, anxiety, depression, and postpartum depression toolkits

Health Net Access reviews health risk assessments (HRAs) for behavioral health indicators and refers these members to RBHA for care.

PHARMACEUTICAL MANAGEMENT

The Health Net Access Pharmacy and Therapeutics (P&T) Committee, which comprises practicing physicians, pharmacists and other health care professionals, reviews the medications on the Health Net Access *Drug List*. The Health Net Access *Drug List* serves as a reference for providers to use when prescribing pharmaceutical products for Health Net Access members with pharmacy coverage. The Health Net Access *Drug List,* which is updated monthly*,* is available on the provider website at provider.healthnet.com under *Pharmacy Information.*

The Health Net Access Pharmacy Department and the P&T Committee consults with external medical specialists, practicing physicians and other health care professionals to aid in the clinical decision-making process. These external reviewers, like the P&T Committee members, are licensed physicians, board-certified in the appropriate specialties, and recognized either locally or nationally for their expertise. The P&T Committee, comprised of actively practicing physicians and pharmacists,

reviews medications based on clinical efficacy, safety, side effects, quality outcomes, and comparisons to existing products, and develops protocols for medications requiring prior authorization through consideration of benefit plans, step-care protocols, quantity or duration limits, benefit exclusions, potential for misuse, potential usage indications that do not meet Food and Drug Administration (FDA) criteria, experimental or off-label use, and required level of laboratory or safety monitoring.

The HNPS Strategic Development Committee may recommend cost-based tier placement in the Health Net Access *Drug List* for medications determined to be clinically equivalent by the P&T Committee.

PHARMACY CLINICAL AND SAFETY INITIATIVES

Health Net Access pharmacy clinical and safety initiatives focus on appropriate narcotic utilization and antibiotic use.

Appropriate Narcotic Utilization Initiative

The primary objectives of the *Appropriate Narcotic Utilization Initiative* are to ensure the proper assessment and treatment of pain through appropriate narcotic use, decrease the use of multiple short-acting narcotic products, decrease excessive intake of acetaminophen-containing products, which may lead to liver toxicity, and improve the coordination of care between prescribers.

Health Net Access sends targeted providers a mailing, including a cover letter, physician reference sheet on pain management and member profiles. Member profiles encourage physicians to review their patients' medication history and promote appropriate utilization through coordination of care. Health Net Access sends targeted members a letter and educational flyer highlighting the safe and correct use of acetaminophen and acetaminophen-containing prescription medications. Additional services and resources are offered through MHN, Health Net Access clinical and wellness programs, and various county programs.

Antibiotic Initiative

The primary objective of the *Antibiotic Initiative* is to promote judicious prescribing of antibiotic medications by providing a toolkit to assist providers in managing antimicrobial therapy.

In collaboration with the Alliance Working for Antibiotic Resistance Education (AWARE), select providers receive a toolkit developed by the AWARE QI Collaborative, including information about upper respiratory tract infections, pediatric pharyngitis, and acute adult bronchitis; flu prevention guideline summaries; and member educational materials. Providers may download the toolkit components from the AWARE website at www.aware.md.

NOTIFICATION OF ACCESS STANDARDS

In accordance with AHCCCS standards, Health Net Access has established access and availability standards that are reviewed and revised annually as needed, and strive to ensure compliance with all applicable state, federal and regulatory requirements. Members have access to a comprehensive provider network and timely access to care.

Health Net Access is committed to monitoring the network and evaluating whether members have sufficient access to providers who meet members' care needs. These include timeliness standards for waiting times for regular and routine appointments, urgent care appointments and after-hours care, as well as provisions for appropriate back-up for absences. The standards are reviewed annually against applicable state and federal regulations and mandates, and are revised as needed. Health Net Access highly recommends that providers review these periodically. Additionally, Health Net Access has recently revised and released updated versions of the after-hours script templates.

The complete set of standards and revised after-hours script templates are available on the provider website at provider.healthnet.com in the Provider Library. Providers who do not have access to the Internet may contact Health Net Access Provider Services to request printed copies of these standards and after-hours script templates.

RIGHTS AND RESPONSIBILITIES

Member Rights and Responsibilities

Health Net Access is committed to treating members in a manner that respects their rights, recognizes their specific needs and maintains a mutually respectful relationship. In order to communicate this commitment, Health Net Access has adopted the following member rights and responsibilities. These rights and responsibilities apply to members' relationships with Health Net Access, its providers and all other health care professionals providing care to its members. They are available on the provider website at provider.healthnet.com or upon request by contacting Health Net Access Provider Services.

Member Rights

A Health Net Access member has the right to:

- Be treated with respect and recognition of his or her dignity and right to privacy.
- Not be discriminated against based on race, ethnicity, national origin, religion, gender, age, intellectual or physical disability, sexual orientation, 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 PCP from Health Net Access participating PCPs, including the right to refuse care from specific providers.
- Participate in decision-making regarding his or her 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 about available treatment options and alternatives, presented in a manner appropriate to the member's 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 the member understands.
- Know about providers who speak languages other than English.
- Be provided with information regarding grievances, appeals and requests for hearings.
- Complain about the managed care organization.
- Have access to review his or her medical records in accordance with applicable federal (Title 45 CFR 164.524) and state laws.
- Request and receive annually, at no cost, a copy of his or her medical records.
- Receive a response from Health Net Access within 30 days of the member's 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 about how to seek review of the denial in accordance with 45 CFR Part 164).
- Amend or correct his or her medical records as specified in 45 CFR 164.526.
- Freely exercise his or her rights without adversely affecting his or her treatment by Health Net Access or associated providers.

Member Responsibilities

A Health Net Access member has the responsibility to:

- Provide, to the extent possible, information needed by professional staff in caring 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 years or younger.

POTENTIAL QUALITY OF CARE ISSUE REFERRALS

In compliance with regulatory requirements and to ensure members receive the highest quality of care, Health Net Access monitors and evaluates potential quality of care issues (PQIs) involving Health Net Access members through the Health Net Access QM Department. PQIs that are reportable to Health Net Access include, but are not limited to, hospital-acquired conditions (HACs), health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs). Providers are expected to report any preventable condition to the Health Net Access QM Department. In addition, providers are required to report any suspected abuse, neglect, exploitation, or unexpected death to the appropriate regulatory agency and the Health Net Access QM Department. The PQI Referral form is available for providers to fax reports of potential or suspected deviation from standards of care that cannot be justified without additional review or investigation. Issues identified as member appeals or grievances, including member complaints, may continue to be referred to the Health Net Access Member Services or Member Appeals and Grievances departments for appropriate resolution.

Potential Quality Issue Referral Form

Providers may access the PQI Referral form in the Provider Library on the provider website at provider.healthnet.com under *Forms*, then search for the Potential Quality Issue Referral Form.

Providers can complete the PQI Referral form and submit it to the Health Net Access QM Department via confidential fax at 1-866-524-5734, preferably within one business day of the incident. The indicators on the form refer to an event or trigger. Use the broad general category lists to identify the potential quality of care issue, or use the *Other* category to describe the incident. Additional completion instructions are provided on the form.

MEMBER APPEALS

A member or a member representative who believes that a determination or application of coverage is incorrect has the right to file an appeal within 60 days from the date of the Notice of Action (NOA). Health Net Access responds to appeals and grievances as follows:

- Standard appeals – acknowledged within five business days and resolved within 30 calendar days. Expedited appeals when waiting for certification could seriously harm the member's health – acknowledged within one calendar day and resolved within three business days.
- Grievances (an expression of dissatisfaction about any matter other than an action) – acknowledged within five business days and resolved within 10 business days, absent extraordinary circumstances. However, resolution must not exceed 90 days. There is no time limit for filing a grievance.

A member who received an unfavorable NOA resolution letter may ask for a state fair hearing. Members have 30 days from the date they received the NOA resolution letter to request a state fair hearing. The member must request a state fair hearing in writing to Health Net Access. State fair hearings are only available for appeals and are not available for grievances.

PRIVACY AND CONFIDENTIALITY

Health Net Access members' protected health information (PHI), whether it is written, oral or electronic, is protected at all times and in all settings. Health Net Access providers can only release PHI without authorization when:

- needed for payment
- necessary for treatment or coordination of care
- used for health care operations (including, but not limited to, HEDIS reporting, appeals and grievances, UM, QI, and disease or care management programs)
- where permitted or required by law

Any other disclosure of a Health Net Access member's PHI must have a prior, written member authorization. Health Net Access providers must ensure that only authorized people with a need-to-know have access to a member's PHI.

Special authorization is required for uses and disclosures involving sensitive conditions, such as psychotherapy notes, HIV/AIDS, behavioral health issues, or substance abuse. To release a member's PHI regarding sensitive conditions, Health Net providers must obtain prior written authorization from the member (or authorized representative), which states the information specific to the sensitive condition that may be disclosed.

MEDICAL RECORD DOCUMENTATION STANDARDS

Health Net Access has established standards for the administration of medical records that ensure medical records conform to good professional medical practice, support health management and permit effective member care. A good medical record

management system not only provides support to clinical providers in the form of efficient data retrieval, but also makes data available for statistical and quality-of-care analyses.

The medical record serves as a detailed analysis of the member's history, a means of communication to assist the multidisciplinary health care team in providing quality medical care, a resource for statistical analysis, and a potential source of defense support information in a lawsuit. It is the provider's responsibility to ensure not only completeness and accuracy of content, but also the confidentiality of the health record. Health Net Access requires that the provider adhere to the standards for maintaining member medical records and to safeguard the confidentiality of medical information.

Providers are responsible for responding to requests for information while protecting the confidentiality interests of Health Net Access members. All providers must have policies and procedures that address confidentiality and the consequences of improper disclosure of member PHI. Refer to the Medical Records Guidelines topic in the Health Net Access provider operations manuals, available online through the provider website at provider.healthnet.com, to review specific levels of medical record security that must be addressed by provider policies and procedures governing the confidentiality of medical records and the release of member PHI.

Health Net Access QM Department monitors medical record documentation compliance and implements appropriate interventions to improve medical recordkeeping. Medical record guidelines are available through the provider website at provider.healthnet.com or upon request by contacting Health Net Access Provider Services.

ADDITIONAL INFORMATION

More extensive information about all the programs described in this update is available on the provider website at provider.healthnet.com. Providers who do not have access to the Internet may request printed copies of provider materials by contacting the Health Net Access Provider Services Center. A complete copy of the Health Net Access QI program description is available on request by sending an email to the QI Department at AHCCCS_Notification@healthnet.com.

A user name and password are required to use the provider website. On the site, select the *Provider* tab at the top of the home page and select *Register Now* in the middle of the page. Each provider office can designate a delegated administrator (usually an information technology, office or security manager) who is responsible for opening accounts and monitoring employee-level access to provider information on the site.

Providers can visit the QI Corner on the provider website at provider.healthnet.com under *Working with Health Net > Quality > Quality Improvement Corner* to view Health Net Access quality outcomes and progress toward goals. The QI Corner also contains tools and materials that can assist providers in delivering care that upholds the standards and performance that members expect.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the provider website at provider.healthnet.com, or by telephone at 1-888-788-4408.

PROVIDER*Update*

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Health Net Access™

Medical Policies – 2nd Quarter 2015

This provider update includes a listing of new and updated Health Net Access, Inc. medical policies approved by the Health Net National Medical Advisory Council (MAC) in the second quarter of 2015. For a complete description of new and updated medical policies, visit the Health Net provider website at provider.healthnet.com and select *Working with Health Net > Clinical > Medical Policies*.

PURPOSE OF HEALTH NET MEDICAL POLICIES

Medical policies provide guidelines for determining medical necessity for specific procedures, equipment and services. All services must be medically necessary to be eligible for benefit coverage, unless otherwise defined in the member's benefits contract. The determination for coverage is also based on all of the terms of the individual member's benefits contract, including, but not limited to, eligibility at the time of service and description of covered benefits, limitations and exclusions. In some cases, legal or regulatory mandate requirements may be applicable and may prevail over medical policy. To the extent there are any conflicts between medical policy guidelines and applicable benefit contract language, the benefit contract language prevails. Medical policy is not intended to override the *Member Handbook* or the health insurance policy that defines the member's benefits, nor is it intended to provide medical advice or dictate to providers how to practice. If required, prior authorization must be obtained before services are rendered.

New Policy

Medical Policy	Policy Statement
LEUPROLIDE FOR BREAST CANCER	Health Net considers leuprolide acetate (Lupron Depot® 3.75 mg) for treatment of premenopausal women with hormone receptor-positive invasive breast cancer medically necessary in combination with either adjuvant endocrine therapy or endocrine therapy for recurrent or metastatic disease.

Updated Policies

Medical Policy	Change
ACCOMMODATING INTRAOCULAR LENS	Added that Health Net Access provides reimbursement for the cost of conventional (standard) or monofocal intraocular lens (IOL) post cataract extraction. Members may choose to receive a premium lens but must agree to assume liability for the additional expense related to these lenses.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- Physicians
- Medical Groups/IPAs
- Hospitals
- Ancillary Providers

PROVIDER SERVICES

az_internetproviderinquiries@healthnet.com
1-888-788-4408
www.healthnet.com

NATIONAL PROVIDER COMMUNICATIONS

provider.communications@healthnet.com
fax 1-800-937-6086

Updated Policies, continued

Medical Policy	Change
ANCA (ANTI-NEUTROPHIL CYTOPLASMIC ANTIBODY) FOR CROHNS DISEASE AND ULCERATIVE COLITIS	Added Prometheus® Anser™ IFX (infliximab) and Prometheus Anser ADA (adalimumab) tests as investigational. Conflicting evidence is available on the association of antibodies to infliximab (ATIs) and antibodies to adalimumab (ATAs) with clinical response to infliximab and adalimumab in patients with inflammatory bowel disease (IBD).
COCHLEAR IMPLANTATION	Added cochlear hybrid implants, such as Nucleus® Hybrid™ L24 Cochlear Implant System, as investigational.
DORSAL COLUMN STIMULATORS	Clarified that required patient screening must include a physical evaluation as well as a face-to-face psychiatric/psychological evaluation conducted by a licensed psychiatrist, psychologist or other licensed mental health professional who has working knowledge of the psychological issues involved in chronic pain syndromes.
GLAUCOMA SURGERY (PREVIOUSLY TITLED ENDOSCOPIC CYCLOPHOTOCOAGULATON (ECP) WITH GLAUCOMA SURGERY AND CATARACT EXTRACTION)	Added iStent® Trabecular Micro-Bypass implanted ab interno, concurrently with cataract surgery for the reduction of intraocular pressure associated with mild to moderate primary open-angle glaucoma, as medically necessary for individuals with specific glaucoma as noted, whose intraocular pressure has not been adequately controlled with ocular hypotensive medication. Note: Health Net Access policies Canaloplasty and ECP with Glaucoma Surgery and Cataract Extraction have been combined into this single policy entitled Glaucoma Surgery.
GASTRIC PACING	Revised policy statement regarding gastric electrical stimulation devices to state it is considered investigational for the treatment of obesity, due to a lack of evidence in the peer review literature demonstrating the long term safety and efficacy of this device. Added information on new U.S. Food and Drug Administration (FDA) approved device, Maestro® Rechargeable System, to scientific rationale.
HUMAN PAPILLOMAVIRUS VACCINE (GARDASIL®, CERVARIX®)	Retired this policy as these vaccines are included in Health Net's Immunization Guidelines, which are based on the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices *(*ACIP) recommendations.
IMPLANTABLE CARDIAC EVENT MONITORS	Added implantable loop recorder cardiac event monitors to evaluate individuals following cryptogenic stroke as investigational.
MECHANICAL STRETCHING DEVICES FOR JOINT STIFFNESS	Added Intrepid Dynamic Exoskeletal Orthosis (IDEO™), a custom dynamic ankle foot orthosis (AFO), as investigational since it is not FDA approved.
MOBILE OUTPATIENT CARDIAC TELEMETRY	Effective for dates of service June 18, 2015, and after, ZIO® Patch is now considered medically necessary to evaluate syncope, presyncope, significant palpitations, or arrhythmia in individuals with a non-diagnostic Holter monitor, or in individuals whose symptoms occur less frequently than once per 48 hours, such that the arrhythmia is unlikely to be diagnosed by Holter monitoring.

Updated Policies, continued

Medical Policy	Change
MOLECULAR TUMOR MARKERS FOR NON-SMALL CELL LUNG CANCER (NSCLC)	Added proteomic testing, such as VeriStrat® testing, for advanced NSCLC and wild-type (no mutation detected) epidermal growth factor receptor (EGFR) or with unknown EGFR status as medically necessary to determine second-line treatment, for individuals who have failed first-line system chemotherapy, according to parameters in the policy.
PHARMACOGENETIC TESTING	Added anaplastic lymphoma kinase (ALK) gene rearrangement testing in NSCLC for prediction of response to crizotinib and ceritinib therapy in ALK-positive metastatic NSCLC patients as medically necessary. This was a 2A recommendation by NCCN. Added Genecept™ Assay as investigational to assist in making treatment recommendations for patients with neuropsychiatric disorders, since there is a paucity of peer-reviewed literature.
STEM CELL TRANSPLANTATION IN ADULTS	Revisions to Allogeneic Transplant section: • Acute lymphocytic leukemia – added additional note under #1 regarding age, and under #6 added criteria deemed high-risk disease. • Chronic myelogenous leukemia – added note under #2 regarding unrelated donors, and added criteria 5-8 based on NCCN recommendations (2.2015). • Multiple myeloma – added that myeloablative allogenic stem cell transplant (SCT) as option only as part of clinical trial with criteria (NCCN 4.2015). • Non-Hodgkin's lymphoma – added individuals with Richter's transformation or Hodgkin's lymphoma following response to initial therapy as additional indications for transplant. Added chronic inflammatory demyelinating polyneuropathy to Other Investigational sections of both autologous and allogeneic transplant.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

PROVIDER*Update*

CONTRACTUAL | JULY 28, 2015 | UPDATE 15-371 | 2 PAGES

Health Net Access™

Prior Authorization Changes and MedSolutions Now eviCore healthcare

This provider update contains information regarding prior authorization changes for Health Net Access, Inc. members, including behavioral health services changes for members eligible for coverage through both Medicare and Medicaid (dual eligible members). Additionally, MedSolutions is now referred to as eviCore healthcare.

BEHAVIORAL HEALTH SERVICES CHANGES

Effective October 1, 2015, dual eligible members have access to behavioral services through Health Net Access. The dual eligible population includes members enrolled in an Arizona Health Care Cost Containment System (AHCCCS) acute health plan, such as Health Net Access, who are also enrolled in Medicare Part A and/or Part B or Part C, which includes any Medicare plan or fee-for-service (FFS) arrangement, whether aligned or not. Aligned members are those members who have their Medicare and Medicaid services provided by the same health plan. Unaligned members may receive Medicare services through one health plan and Medicaid services through another. Regional Behavioral Health Authorities (RBHAs) and/or the Tribal/Regional Behavioral Health Authorities (T/RBHAs) will continue to administer benefits for children, individuals with serious mental illness (SMI) and those who are not dually eligible for Medicare and Medicaid.

Accordingly, the following additions have been made to the Health Net Access prior authorization requirements for dual eligible members. Prior authorization requests for any of these services, procedures or equipment is coordinated through Health Net Access by calling (888) 926-1736 or faxing a request to (855) 764-8513.

Inpatient Services

- behavioral health or detoxification

Outpatient Procedures, Services or Equipment

- electroconvulsive therapy (ECT)
- psychological testing

PRIOR AUTHORIZATION CHANGES

Effective immediately, the following changes have been made to the Health Net Access prior authorization requirements for all Health Net Access members.

- dermatology (in-office procedures) – the CPT code 17250 for laser treatment has been removed
- dialysis – the notification requirement for dialysis has been removed

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- Physicians
- Medical Groups/IPAs
- Hospitals
- Ancillary Providers

PROVIDER SERVICES

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fax 1-800-937-6086

MEDSOLUTIONS NOW EVICORE HEALTHCARE

MedSolutions is now eviCore healthcare as part of the company's rebranding and renaming initiative. This change does not affect how prior authorization requests for outpatient diagnostic procedures are submitted; however, providers may notice the transition of names and logos on the MedSolutions website, provider portal and letters in the coming months.

Providers may continue to access www.medsolutions.com to initiate prior authorization requests for outpatient diagnostic procedures, or they may use the new website, www.evicore.com. The telephone and fax numbers to submit requests remain as follows:

1-888-693-3211
Fax: 1-888-693-3210

ADDITIONAL INFORMATION

The Health Net Access provider operations manuals will be changed to reflect eviCore healthcare, and can be accessed through the Provider Library on the Health Net provider website at provider.healthnet.com under *Operations Manuals > Prior Authorization.* The Health Net Access prior authorization requirements will also be changed to reflect eviCore healthcare, in addition to the prior authorization changes described in this update.

Prior authorization requirements are available at provider.healthnet.com both pre-log in and post-log in. To access them pre-log in, go to *Working with Health Net > Policies for Non-Contracting Providers > Additional Resources > Services Requiring Prior Authorization*. To access them post-log in, go to *Working with Health Net > Contractual > Services Requiring Prior Authorization*. Information regarding Health Net's prior authorization policies and procedures is available in the provider operations manuals.

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

Update your info online

Is your demographic information current for Health Net provider directories and the online ProviderSearch function? Submit updates and corrections, including information regarding practice locations, provider names, languages spoken at the practice, and office hours, on the provider website at provider.healthnet.com by selecting *My Account > Update Provider Information.*

PROVIDER*Update*

CONTRACTUAL | JULY 24, 2015 | UPDATE 15-366 | 1 PAGE

Health Net Access™

General Mental Health and Substance Abuse Benefit Integration for Dual Eligible Members

Effective October 1, 2015, Health Net Access, Inc. is required to provide general mental health and substance abuse (GMH/SA) services to dual eligible members in place of the Regional Behavioral Health Authority (RBHA) system. Dual eligible members are eligible for both Medicare and Medicaid benefits. Medicare continues to be the primary payer for behavioral health services with Health Net Access as the secondary payer.

The dual eligible population includes members enrolled in an Arizona Health Care Cost Containment System (AHCCCS) acute care health plan, such as Health Net Access, who are also enrolled in Medicare Part A and/or Part B (any Medicare plan or fee-for-service (FFS) arrangement, whether aligned or not). Aligned members are those members who have their Medicare and Medicaid services provided by the same health plan. Unaligned members may have Medicare with one health plan and Medicaid with another.

GMH/SA INTEGRATION

Beginning October 1, 2015, delivery of GMH/SA services for Health Net Access dual eligible members currently receiving behavioral health services with the RBHA is transitioning to Health Net Access. The goal of the integration is to improve services delivery by providing one set of comprehensive benefits – acute medical and behavioral health benefits – and the provision of one primary and secondary payer through Health Net Access.

Members are managed by a single, coordinated care team and have one comprehensive individualized care plan that addresses both physical and behavioral health needs. Additionally, all services provided by the RBHA are included in this transition.

EXCEPTIONS

Children receiving behavioral health services continue to receive those services through the RBHA. Members with serious mental illness (SMI) are also excluded and continue to receive both medical and behavioral health services through the RBHA. In Maricopa County, the RBHA function is provided by Mercy Maricopa Integrated Care (MMIC).

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- ● Physicians
- ● Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

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 OTH002601EW00 (7/15)

PROVIDER*Update*

CONTRACTUAL | JULY 23, 2015 | UPDATE 15-367 | 1 PAGE

Health Net Access™

Changes to AHCCCS Minimum Subcontract Provisions

The Arizona Health Care Cost Containment System (AHCCCS) made changes to its Minimum Subcontract Provisions (MSPs), effective July 1, 2015. In February 2015, Health Net Access, Inc. sent *Provider Participation Agreement* (*PPA*) amendments to providers to ensure their *PPAs* are compliant with AHCCCS MSPs.

Changes to AHCCCS MSPs automatically amend providers' *PPAs.* Providers may access updated MSPs on the AHCCCS website at www.azahcccs.gov/commercial/MinimumSubcontractProvisions.aspx.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at 1-888-788-4408.

Update your info online

Is your demographic information current for Health Net provider directories and the online ProviderSearch function? Submit updates and corrections, including information regarding practice locations, provider names, languages spoken at the practice, and office hours, on the provider website at provider.healthnet.com by selecting *My Account* > *Update Provider Information*.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

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PROVIDER*Update*

CONTRACTUAL | JULY 21, 2015 | UPDATE 15-335 | 3 PAGES

Health Net Access™

Interpreter Services and Cultural Training

Health Net Access, Inc. offers participating physicians, medical groups, ancillary providers, and members 24-hour access to telephonic interpreter services. Additionally, Health Net Access offers in-person interpreter services, as well as sign language assistance, during business hours at no cost. These services feature the following:

- qualified interpreters training on health care terminology and a wide range of interpreting protocols and ethics
- support to address common communication challenges across cultures

This communication describes Health Net Access interpreter services and lists access information.

INTERPRETER SERVICES

Health Net Access provides interpreter support for limited-English proficient (LEP) members at all medical points of contact. Providers are asked to make accommodations to use telephone interpreters as that may be the only service available for the appointment time or language. Health Net Access recommends three to five days advance notice to schedule in-person interpreters. Telephone interpreter services do not need to be scheduled in advance of the appointment; however, providers need to allow adequate time before the appointment time to get the telephone interpreter on the line. Providers who have questions or need interpreter services may contact the Provider Services Center at (888) 788-4408, 24 hours a day, seven days a week. In-person interpreters are available between 7:00 a.m. and 6:00 p.m., Monday through Friday. When calling, providers must have available the member's name, Health Net Access identification (ID) number, and appointment date and time, if necessary.

CULTURAL AND LINGUISTIC APPROPRIATENESS

Health Net Access provides the following to comply with mandated cultural and linguistic appropriateness standards:

- oral language services that include answering questions and providing assistance in more than 150 non-English languages
- upon request, Spanish translation of vital documents that provide information about eligibility and how to participate in the plan
- a statement indicating how to access language services in the most common non-English languages spoken in Arizona

PROVIDER RESPONSIBILITIES

Participating providers may use Health Net Access interpreter services to provide interpreters to members who require or request them. Participating providers must ensure that language services meet the established requirements as follows:

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- ● Physicians
- ● Medical Groups/IPAs
- ○ Hospitals
- ● Ancillary Providers

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- Ensure that LEP members are not subject to unreasonable delays in the delivery of services including access to providers after hours.
- Do not require or encourage members to use family members or friends as interpreters. Health Net Access strongly discourages the use of minors as interpreters, unless used in an emergency situation.
- Provide interpreter services at no cost to members.
- Extend same participation opportunities in programs and activities to all members regardless of their language preferences.
- Provide services to LEP members that are as effective as those provided to others.
- Record the language needs of each member, as well as the member's request or refusal of interpreter services, in his or her medical record.
- Advise members that they may file grievances with Health Net Access if their language needs are not met.

PROVIDERS DELEGATED FOR UTILIZATION MANAGEMENT ONLY

In addition to the above, providers delegated for utilization management (UM) must comply with the following:

- Translation services – Upon request, provide Health Net Access with the documents sent to members in a timely manner. If a Health Net Access member requests translation of an English document that was produced by an ancillary provider on Health Net Access' behalf, the provider must refer the member to the Health Net Customer Contact Center (CCC) telephone number listed on the member's ID card. When the Health Net Access CCC receives the member's request, Health Net contacts the provider requesting a copy of the specific English document for translation. The provider must submit the document within 48 hours of the Health Net Access request.
- Notice of Language Assistance (NOLA) – Include Health Net Access-specific NOLA, which advises members that they can receive support in their preferred language, with vital documents distributed to Health Net Access members (for example, UM denial and delay notices, and claims notices that require member action). A sample notice is available in the provider operations manuals on the Health Net provider website at provider.healthnet.com. From the Provider Library, choose the appropriate audience and product line, and select *Forms > Notice on the Availability of Language Assistance.*

CULTURAL COMPETENCY TRAINING

All Health Net Access participating providers are requested to take cultural competency training. The United States Department of Health and Human Services' Office of Minority Health (OMH) offers a computer-based training (CBT) program, *A Physician's Practical Guide to Culturally Competent Care,* on cultural competency for health care providers. The cultural competency curriculum modules (CCCMs) are available to physicians, physician assistants (PAs) and nurse practitioners (NPs), and are self-paced. They were developed to furnish providers with competencies that enable them to better treat an increasingly diverse population. This no-cost educational program is available to providers through the OMH Think Cultural Health website at https://cccm.thinkculturalhealth.hhs.gov. Health Net Access does not sponsor or maintain the OMH CBT or website.

The OMH Think Cultural Health website contains a variety of self-assessments, case studies, video vignettes, learning points, continuing medical education (CME) post-tests, and the opportunity to submit feedback and view other participants' feedback about the cases and content. It also includes links to health care community advocacy and consumer groups.

CME Credits

The Professional Education Services Group (PESG) designates the OMH CCCMs for a maximum of nine category-one CME credits toward the American Medical Association (AMA) Physician's Recognition Award. Physicians may claim credits upon completion in the activity. Additional CME information is available at https://cccm.thinkculturalhealth.hhs.gov under *Earn Credit.*

Getting Started

Providers can register online at https://cccm.thinkculturalhealth.hhs.gov to complete the OMH cultural competency educational activity. The registration process includes standard demographic questions required for all CME activities. Once registered, providers may enter their user name and password to access the site. Each time providers log in to the site, they are directed to the page where they left off on the previous visit.

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

Providers who would like information about cross-cultural communication, health literacy or accessing interpreter services may contact Health Net's C&L Services Department by email at Cultural.and.Linguistic.Services@healthnet.com or by telephone at (800) 977-6750. For all other questions, contact the Health Net Access Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

Update your info online

Is your demographic information current for Health Net provider directories and the online ProviderSearch function? Submit updates and corrections, including information regarding practice locations, provider names, languages spoken at the practice, and office hours, on the provider website at provider.healthnet.com by selecting *My Account > Update Provider Information*.

PROVIDER *Update*

CONTRACTUAL | JULY 7, 2015 | UPDATE 15-316 | 1 PAGE

Health Net Access™

Prior Authorization for Makena™

Makena™ is subject to prior authorization by Health Net Pharmaceutical Services (HNPS) for all Health Net Access, Inc. members when submitted under medical benefit claims.

As indicated by the Food and Drug Administration (FDA), Makena is approved to reduce the risk of preterm birth in women with singleton pregnancies who have histories of singleton spontaneous preterm birth. In accordance with Health Net Access prior authorization guidelines, prior authorization may be obtained from HNPS if the member has a:

- confirmed pregnancy with a single fetus between 16 weeks, 0 days and 20 weeks, 6 days of gestation, and
- history of single fetus spontaneous preterm birth prior to 37 weeks of gestation.

Providers should note that the initial dose must be started in the same time frame and continued once weekly until week 37 (through 36 weeks, 6 days) of gestation or delivery, whichever occurs first, in accordance with the FDA package insert, *Dosage and Administration*.

Additional information regarding Health Net's prior authorization guidelines for Makena is available on the Health Net provider website at provider.healthnet.com, under *Pharmaceutical Services > Prior Authorization Commercial Plans and State Health Programs > View Our Prior Authorization Guidelines > Makena*.

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

Online Medical Policies

Health Net develops evidence-based medical policies through critical appraisal of current published peer-reviewed medical literature to support providers in determining medical necessity for specific procedures, equipment and services. Medical policies are located on the Health Net provider website at provider.healthnet.com under *Working with Health Net > Clinical > Medical Policies.*

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- ● Physicians (OB/GYNs)
- ○ Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

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 OTH002245EW00 (07/15)

Health Net, Inc.

PROVIDER*Update*

Health Net®

NEWS & ANNOUNCEMENTS | JULY 2, 2015 | UPDATE 15-330 | 2 PAGES

Health Net and Centene today announced that the two companies will combine to create a leading diversified health care services enterprise with more than 10 million members across the country. The transaction is subject to regulatory review, stockholder approval and other customary closing conditions. Details are in our news release.

Our two organizations will immediately begin seeking all necessary regulatory approvals, and we expect it to close in early 2016.

Through all the upcoming activities, Health Net will continue being laser-focused on the needs of our customers and providers, who both have come to depend on us for quality, affordable health insurance coverage and service.

We are working hard to ensure that our customers and business partners experience a seamless transition of services, and Centene shares this commitment.

Our combined organization will be better equipped to address new business opportunities from the Affordable Care Act, bringing greater scale and operational resources to the commercial, Medicare, Cal MediConnect, and Medicaid expansion programs so vital to the success of our country's health care future.

If you have any questions, please contact Health Net's Contact Center at 1-800-289-2818.

Forward Looking Statements

This document contains certain forward-looking statements with respect to the financial condition, results of operations and business of Centene, Health Net and the combined businesses of Centene and Health Net and certain plans and objectives of Centene and Health Net with respect thereto, including the expected benefits of the proposed merger. These forward-looking statements can be identified by the fact that they do not relate only to historical or current facts. Forward-looking statements often use words such as "anticipate", "target", "expect", "estimate", "intend", "plan", "goal", "believe", "hope", "aim", "continue", "will", "may", "would", "could" or "should" or other words of similar meaning or the negative thereof. There are several factors which could cause actual plans and results to differ materially from those expressed or implied in forward-looking statements. Such factors include, but are not limited to, the expected closing date of the transaction; the possibility that the expected synergies and value creation from the proposed merger will not be realized, or will not be realized within the expected time period; the risk that the businesses will not be integrated successfully; disruption from the merger making it more difficult to maintain business and operational relationships; the risk that unexpected costs will be incurred; changes in economic conditions, political conditions, changes in federal or state laws or regulations, including the Patient Protection and Affordable Care Act and the Health Care Education Affordability Reconciliation Act and any regulations enacted thereunder, provider and state contract changes, the outcome of pending legal or regulatory proceedings, reduction in provider payments by governmental payors, the expiration of Centene's or Health Net's Medicare or Medicaid managed care contracts by federal or state governments and tax matters; the possibility that the merger does not

THIS UPDATE APPLIES TO:

- Physicians
- Participating Physician Groups/ Medical Groups/IPAs
- Hospitals
- Ancillary Providers

STATE:

- Arizona
- California
- Oregon/Washington

LINES OF BUSINESS:

- All

ARIZONA

az_internetproviderinquiries@healthnet.com
HMO, PPO, POS, Medicare Advantage – (800) 289-2818
Health Insurance Marketplace – (888) 926-1870

CALIFORNIA

provider_services@healthnet.com
HMO/POS, PPO & EPO – (800) 641-7761
Medicare Programs – (800) 929-9224
Cal MediConnect:
Los Angeles County – (855) 464-3571
San Diego County – (855) 464-3572
Medi-Cal – (800) 675-6110
Covered California – (888) 926-2164

OREGON/WASHINGTON

EPO, POS, PPO, & CommunityCare – (888) 802-7001
Medicare Advantage HMO/PPO – (888) 445-8913

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close, including, but not limited to, due to the failure to satisfy the closing conditions, including the receipt of approval of both Centene's stockholders and Health Net's stockholders; the risk that financing for the transaction may not be available on favorable terms; and risks and uncertainties discussed in the reports that Centene and Health Net have filed with the Securities and Exchange Commission (the "SEC"). These forward-looking statements reflect Centene's and Health Net's current views with respect to future events and are based on numerous assumptions and assessments made by Centene and Health Net in light of their experience and perception of historical trends, current conditions, business strategies, operating environments, future developments and other factors they believe appropriate. By their nature, forward-looking statements involve known and unknown risks and uncertainties because they relate to events and depend on circumstances that will occur in the future. The factors described in the context of such forward-looking statements in this announcement could cause Centene's and Health Net's plans with respect to the proposed merger, actual results, performance or achievements, industry results and developments to differ materially from those expressed in or implied by such forward-looking statements. Although it is believed that the expectations reflected in such forward-looking statements are reasonable, no assurance can be given that such expectations will prove to have been correct and persons reading this announcement are therefore cautioned not to place undue reliance on these forward-looking statements which speak only as of the date of this announcement. Neither Centene nor Health Net assumes any obligation to update the information contained in this announcement (whether as a result of new information, future events or otherwise), except as required by applicable law. A further list and description of risks and uncertainties can be found in Centene's Annual Report on Form 10-K for the fiscal year ended December 31, 2014 and in its reports on Form 10-Q and Form 8-K as well as in Health Net's Annual Report on Form 10-K for the fiscal year ended December 31, 2014 and in its reports on Form 10-Q and Form 8-K.

Additional Information and Where to Find It

The proposed merger transaction involving Centene and Health Net will be submitted to the respective stockholders of Centene and Health Net for their consideration. In connection with the proposed merger, Centene will prepare a registration statement on Form S-4 that will include a joint proxy statement/prospectus for the stockholders of Centene and Health Net to be filed with the SEC, and each will mail the joint proxy statement/prospectus to their respective stockholders and file other documents regarding the proposed transaction with the SEC. **Centene and Health Net urge investors and stockholders to read the joint proxy statement/prospectus when it becomes available, as well as other documents filed with the SEC, because they will contain important information.** Investors and security holders will be able to receive the registration statement containing the joint proxy statement/prospectus and other documents free of charge at the SEC's web site, http://www.sec.gov. These documents can also be obtained (when they are available) free of charge from Centene upon written request to the Investor Relations Department, Centene Plaza 7700 Forsyth Blvd. St. Louis, MO 63105, (314) 725-4477 or from Centene's website, http://www.centene.com/investors/, or from Health Net upon written request to the Investor Relations Department, Health Net, Inc. 21650 Oxnard Street Woodland Hills, CA 91367, (800) 291-6911, or from Health Net's website, www.healthnet.com/InvestorRelations.

Participants in Solicitation

Centene, Health Net and their respective directors and executive officers and other members of management and employees may be deemed to be participants in the solicitation of proxies from the respective stockholders of Centene and Health Net in favor of the merger. Information regarding the persons who may, under the rules of the SEC, be deemed participants in the solicitation of the respective stockholders of Centene and Health Net in connection with the proposed merger will be set forth in the joint proxy statement/prospectus when it is filed with the SEC. You can find information about Centene's executive officers and directors in its definitive proxy statement for its 2015 Annual Meeting of Stockholders, which was filed with the SEC on March 16, 2015. You can find information about Health Net's executive officers and directors in its definitive proxy statement for its 2015 Annual Meeting of Stockholders, which was filed with the SEC on March 26, 2015. You can obtain free copies of these documents from Centene and Health Net using the contact information above.

No Offer or Solicitation

This communication shall not constitute an offer to sell or the solicitation of an offer to sell or the solicitation of an offer to buy any securities, nor shall there be any sale of securities in any jurisdiction in which such offer, solicitation or sale would be unlawful prior to registration or qualification under the securities laws of any such jurisdiction. No offer of securities shall be made except by means of a prospectus meeting the requirements of Section 10 of the Securities Act of 1933, as amended, and otherwise in accordance with applicable law.

PROVIDER*Update*

CONTRACTUAL | JUNE 23, 2015 | UPDATE 15-283 | 2 PAGES

Health Net Access™

Health Net Access Medical Record Review Process

The Health Net Access, Inc. medical record review (MRR) process is designed to ensure consistent and thorough medical recordkeeping among all contracting physicians and pediatricians who function as primary care physicians (PCPs), as well as obstetricians/gynecologists (OB/GYNs) and high-volume specialists. The MRR process includes a review of 30 clinical charts at least once every three years for these contracting providers.

Upon completion of the MRR, Health Net Access sends results to individual providers. A minimum score of 85 percent is required to pass. The Health Net Access quality compliance nurse discusses with the provider any elements of the MRR process for which the provider is non-compliant at the time of the review. Any provider who scores less than 85 percent on the MRR requires a follow-up MRR performed six months after the initial MRR.

ANALYSIS AND TRENDS

Health Net Access analyzes results of MRRs on a quarterly basis and identifies trends. The Health Net Access Quality Management – Performance Improvement Committee (QM-PIC) develops interventions and provider education based on these trends and any trends that are similar from quarter to quarter.

Over the first and second quarters of 2015, the Health Net Access QM-PIC has identified frequently missing key elements of required documentation for all Health Net Access and Arizona Health Care Cost Containment System (AHCCCS) contracting providers. The following documentation has not been consistently included in medical records based on MRRs conducted over the last two quarters:

- Patients of reproductive age (ages 12 to 55) are informed of the availability of family planning.
- Patients ages 50 and older have fecal occult blood tests performed.
- Patients are assessed for smoking, alcohol and substance use.
- Providers use an approved developmental tool for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits at 9, 18 and 24 months.
- Providers who see both adults and children use EPSDT forms for visits involving children.
- Risk assessments performed by OB/GYNs include an assessment for the risk of domestic violence.

In addition to the trends identified above, the Health Net Access QM-PIC has also identified the following trends in MRR reviews over the last two quarters:

- documentation of flu vaccines
- documentation of supervision by the physician for physician assistants (PAs)
- documentation of advanced directives for patients ages 18 and older

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- ● Physicians
- ● Medical Groups/IPAs
- ○ Hospitals
- ● Ancillary Providers

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fax (800) 937-6086

 OTH002058EW00 (06/15)

- documentation of any follow-up for no-show patients
- Pap tests and mammograms for female patients
- antepartum and postpartum depression screening

ADDITIONAL INFORMATION

Additional information about Health Net Access medical record policies and procedures is available in the Health Net Access provider operations manuals, which can be accessed in the Provider Library on the Health Net provider website at provider.healthnet.com. Providers may also reference Chapters 400 and 900 of the Arizona AHCCCS Medical Policy Manual (AMPM) at www.azahcccs.gov/shared/MedicalPolicyManual/MedicalPolicyManual.aspx.

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

Online Medical Policies

Health Net develops evidence-based medical policies through critical appraisal of current published peer-reviewed medical literature to support providers in determining medical necessity for specific procedures, equipment and services. Medical policies are located on the Health Net provider website at provider.healthnet.com under *Working with Health Net > Clinical > Medical Policies*.

PROVIDER*Update*

CONTRACTUAL | JUNE 18, 2015 | UPDATE 15-272 | 1 PAGE

Health Net Access™

Medical Policy for Mobile Outpatient Cardiac Telemetry Updated

Health Net's Medical Advisory Council (MAC) has updated the Health Net Access, Inc. Mobile Outpatient Cardiac Telemetry medical policy.

PURPOSE OF HEALTH NET MEDICAL POLICIES

Medical policies provide guidelines for determining medical necessity for specific procedures, equipment and services. All services must be medically necessary to be eligible for benefit coverage, unless otherwise defined in the member's benefits contract. The determination for coverage is also based on all of the terms of the individual member's benefits contract, including, but not limited to, eligibility at the time of service and description of covered benefits, limitations and exclusions. In some cases, legal or regulatory mandate requirements may be applicable and may prevail over medical policy. To the extent there are any conflicts between medical policy guidelines and applicable benefit contract language, the benefit contract language prevails. Medical policy is not intended to override the *Member Handbook* or the health insurance policy that defines the member's benefits, nor is it intended to provide medical advice or dictate to providers how to practice. If required, prior authorization must be obtained before services are rendered.

Updated Policy

Medical Policy	Change
MOBILE OUTPATIENT CARDIAC TELEMETRY	Effective with dates of service June 18, 2015, and after, ZIO® Patch is now considered medically necessary to evaluate syncope, presyncope, significant palpitations, or arrhythmia in individuals with a non-diagnostic Holter monitor, or in individuals whose symptoms occur less frequently than once per 48 hours such that the arrhythmia is unlikely to be diagnosed by Holter monitoring

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- Physicians
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CONTRACTUAL | JUNE 15, 2015 | UPDATE 15-271 | 2 PAGES

Health Net Access™

Requirements for Sterilization Services

Health Net Access, Inc. provides coverage for sterilization under family planning benefits. 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.
- Thirty 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 sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

CONSENT FORM

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. The sterilization consent form is available on the Health Net Access website at provider.healthnet.com in the Provider Library under *Forms > Sterilization Consent Form.*

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 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; and
- notification that sterilization cannot be performed for at least 30 days post-consent.

Sterilization consent may not be obtained when a member is:

- in labor or childbirth,
- seeking to obtain, or is obtaining, pregnancy termination; or

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 OTH002233EW00 (6/15)

- under the influence of alcohol or other substances that affect that member's state of awareness.

Providers must also complete the Health Net Access Request for Prior Authorization form and send it, along with the Sterilization Consent Form, to the Health Net Prior Authorization Department via fax at (855) 764-8513. The request for prior authorization form is available on the Health Net Access website at provider.healthnet.com in the Provider Library under *Forms > Health Net Access Request for Prior Authorization.*

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

Online Medical Policies

Health Net develops evidence-based medical policies through critical appraisal of current published peer-reviewed medical literature to support providers in determining medical necessity for specific procedures, equipment and services. Medical policies are located on the Health Net provider website at provider.healthnet.com under *Working with Health Net > Clinical > Medical Policies.*

Health Net Access, Inc.
1230 W. Washington St., Suite 401
Tempe, Arizona 85281
602.794.1400
888.788.4408
www.healthnet.com

Date

<Entity Name>
<First name> <Last name>, <Title> *or* Administrator
<Address>
<City>, <State> <ZIP>

Re: *PPA* Amendment 4.2.2 Payment

Dear <Title>. <Last Name> *or* Administrator:

Enclosed is an amendment to your Health Net Access, Inc. *Provider Participation Agreement (PPA)*, effective August 1, 2015, pertaining to an increase in commercial and Health Net Access interest rates on late claims.

Please return a signed copy of the amendment to our attention by July 15, 2015, via secure fax or mail, as listed below. You may also submit a copy of the amendment to your assigned Provider Network Management representative.

	TEMPE	**TUCSON**
FAX	(602) 794-1803	(520) 258-5172
MAILING ADDRESS	Health Net of Arizona, Inc. Attention: Provider Network Management 1230 W. Washington Street, Suite 401 Tempe, AZ 85281	Health Net of Arizona, Inc. Attention: Provider Network Management 5255 E Williams Circle, Suite 4000 Tucson, AZ 85711

If you have any questions, please contact the Health Net Access Provider Services Center at (888) 788-4408.

Sincerely,

Jacqueline Thames
Director, Provider Network Management

Enclosure

AMENDMENT
to the
PROVIDER PARTICIPATION AGREEMENT
between
HEALTH NET OF ARIZONA, INC.
and
PROVIDER

This is an Amendment to the original Participating Agreement entered into by Provider and between Health Net of Arizona, Inc. on behalf of its subsidiaries and affiliates of Health Net, Inc. (collectively "Health Net") and Provider. This Amendment is an integral part of the Agreement and shall supersede any contractual provisions to the contrary as of the effective date below.

NOW THEREFORE, in consideration of the mutual considerations contained in this Amendment, both parties hereby agree to amend the Agreement as follows:

4.2 **Billing and Payment**, 4.2.2 **Payment** shall be deleted in its entirety and replaced with the following:

4.2.2 **Payment.** Health Net or Payor shall approve or deny each of Provider's timely-submitted Clean Claims within 30 days of receipt of such claim, and shall pay approved Clean Claims within 30 days of approval. All payments shall be made in accordance with Health Net Policies. Interest will be paid at the rate determined by CMS for Clean Claims not paid within 30 days of approval, for Medicare Advantage claims. Commercial and AHCCCS interest rates shall be determined by the State of Arizona for Clean Claims not paid within 30 days of approval. Overdue payments shall bear interest in accordance with Health Net Policies. Interest on overdue payments shall be calculated beginning on the date that payment to Provider is due. Payment of interest shall be Provider's sole remedy for failure of Health Net or Payor to make timely payments. In no event shall Health Net be under any obligation to pay Provider for any claim, payment of which is the responsibility of another Payor under a particular Benefit Plan, including without limitation self-funded health plans. A self-funded health plan is a Benefit Program that Health Net administers, but does not insure or underwrite the liability of, and that retains the financial responsibility for payment of (i) claims for coverage under such Benefit Programs and (ii) any expenses incident to the Benefit Program except those specifically assumed by Health Net in any administrative services agreement between the self-funded health plan or its sponsor and Health Net. Notwithstanding the foregoing, Provider may submit claims grievance in accordance with Health Net Policies.

IN WITNESS WHEREOF, the parties have executed this Amendment to be effective on August 1, 2015. All other terms and conditions of the Agreement remain in full force and effect.

PROVIDER	**HEALTH NET OF ARIZONA, INC.**
_____	_____
Signature	Signature
_____	**Rose Megian**
Print Name	Print Name
_____	President and Regional Health Plan Officer
Title	Title
_____	_____
Date	Date
_____	
Federal Tax Identification Number	
_____	
Name of Tax Identification Number Owner	

PROVIDER*Update*

CONTRACTUAL | MAY 29, 2015 | UPDATE 15-235 | 1 PAGE

Health Net Access™

Arizona Early Intervention Program

Arizona Early Intervention Program (AzEIP) provides services to children from birth through age three who are at risk for or have developmental delays. Services include education and support to children's families to optimize child health and development. Primary care physicians (PCPs) must coordinate with AzEIP to identify children with developmental disabilities needing services, including family education and support needs.

Health Net Access, Inc. and the Arizona Health Care Cost Containment System (AHCCCS) require PCPs to communicate the results of assessments and services provided to AzEIP enrollees within 45 days of the member's AzEIP enrollment.

REFERRAL

During Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits, PCPs must document concerns about a child's development on the EPSDT Tracking form, and refer children to AzEIP when the PCP identifies such concerns. Following the referral, AzEIP contacts the family and schedules an assessment that includes the development of an Individualized Family Service Plan (IFSP). The Health Net Access Prior Authorization Department reviews IFSPs for medical necessity prior to authorization and reimbursement.

Health Net Access EPSDT coordinators are available to provide additional information on AzEIP, and coordinate all services identified as medically necessary, including referring members who require behavioral health services.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

Take Advantage of Health Net's Online Tools

Visit Health Net's provider portal directly at provider.healthnet.com. Once logged in, quickly find and verify member eligibility, copayments, prior authorization requirements, and other plan details under *Patient Information* for a selected member. View his or her transaction status under *Patient History* to find what you need, when you need it.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- ● Physicians
- ● Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

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PROVIDER*Update*

CONTRACTUAL | MAY 26, 2015 | UPDATE 15-226 | 1 PAGE

Health Net Access™

SOBRA Benefits Reminder

Sixth Omnibus Budget Reconciliation Act (SOBRA) members who became eligible for Health Net Access, Inc. plans due to pregnancy may lose their Health Net Access eligibility 60 days after delivering their newborns.

REFERRING SOBRA MEMBERS

Primary care physicians (PCPs) or Health Net Access should inform pregnant SOBRA members that it is possible for them to lose their Health Net Access benefits at any time if they no longer meet eligibility requirements. Providers should notify members that they can access no-cost or low-cost family planning services as well as primary care services through some clinics and primary care service providers, in the event members become ineligible for Health Net Access benefits. A list of no-cost or low-cost primary care service providers is available on the Arizona Department of Health Services (ADHS) website at www.azdhs.gov/hsd/sliding-fees/documents/sliding-fee-primary-care-providers.pdf.

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

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THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

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PROVIDER*Update*

NEWS & ANNOUNCEMENTS | MAY 14, 2015 | UPDATE 15-210 | 1 PAGE

Health Net Access™

Status for Inventoried Claims Now Available on the Provider Portal

Health Net Access, Inc. (Health Net) providers who have registered for a provider website account have access to the online claims inquiry tool, which allows them to view the status of claims they have submitted. Health Net's claims inquiry function is designed to provide access to up-to-date information on claims, such as claim number, billed amount, paid amount, and claim status.

Until a recent system update, providers were only able to view the status of claims that were in process and assigned a claim number. With the update, providers are now able to view and confirm receipt of claims that are in an inventory status.

To access the online claims inquiry tool, providers must log in to Health Net's provider website at provider.healthnet.com, then select *Transactions > Claims > Check Claims Status* and follow the prompts.

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

Take Advantage of Health Net's Online Tools

Visit Health Net's provider portal directly at provider.healthnet.com. Once logged in, quickly find and verify member eligibility, copayments, prior authorization requirements, and other plan details under *Patient Information* for a selected member. View his or her transaction status under *Patient History* to find what you need, when you need it.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

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PROVIDER *Update*

CONTRACTUAL | MAY 11, 2015 | UPDATE 15-193 | 3 PAGES

Health Net Access™

Medical Policies – 1st Quarter 2015

This provider update includes a listing of updated preventive health guidelines, clinical practice guidelines, and new, updated and retired Health Net Access, Inc. (Health Net) medical policies approved by the Health Net National Medical Advisory Council (MAC) in the first quarter of 2015. For a complete description of new and updated medical policies, visit the Health Net provider website at provider.healthnet.com and select *Working with Health Net > Clinical > Medical Policies*.

PURPOSE OF HEALTH NET MEDICAL POLICIES

Medical policies provide guidelines for determining medical necessity for specific procedures, equipment and services. All services must be medically necessary to be eligible for benefit coverage, unless otherwise defined in the member's benefits contract. The determination for coverage is also based on all of the terms of the individual member's benefits contract, including, but not limited to, eligibility at the time of service and description of covered benefits, limitations and exclusions. In some cases, legal or regulatory mandate requirements may be applicable and may prevail over medical policy. To the extent there are any conflicts between medical policy guidelines and applicable benefit contract language, the benefit contract language prevails. Medical policy is not intended to override the *Member Handbook* or the health insurance policy that defines the member's benefits, nor is it intended to provide medical advice or dictate to providers how to practice. If required, prior authorization must be obtained before services are rendered.

Preventive Health Guidelines

Topic	Summary
2015 ADULT FEMALE AND MALE PREVENTIVE HEALTH GUIDELINES	Guideline updates are based on recommendations from the United States Preventive Services Task Force (USPSTF) and other professional societies
2015 ADULT IMMUNIZATION SCHEDULE	This schedule is based on 2015 recommendations from the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP)
2015 CHILDHOOD AND ADOLESCENT IMMUNIZATION SCHEDULE WITH CATCH-UP	This schedule is based on 2015 recommendations from ACIP
2015 MATERNITY HEALTH GUIDELINES	Guideline updates are based on American Congress of Obstetricians and Gynecologists (ACOG) recommendations
2015 PEDIATRIC PREVENTIVE HEALTH GUIDELINES	Guideline updates are based on recommendations from the American Academy of Pediatrics (AAP)

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

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New Policy

Medical Policy	Policy Statement
IMAGE GUIDED (COMPUTER ASSISTED) ENDOSCOPIC SINUS SURGERY	This policy was developed to provide guidance as to when image-guided sinus surgery is indicated. Criteria is based on recommendations from the American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS) and supported by the American Rhinologic Society (ARS)

Updated Policies

Medical Policy	Change
BUPRENORPHINE TREATMENT	Changed from a clinical practice guideline to a policy since it is used for authorization decisions. Added information on overuse of prescription opioid use in pain management and other contextual changes
CAROTID ANGIOPLASTY AND STENTING	Revised policy statement to reflect recommendations from the American College of Cardiology Foundation/American Heart Association Task Force (ACCF/AHA) along with other professional societies regarding the management of patients with extracranial carotid and vertebral artery disease
COLONOSCOPY	Numerous updates to policy based on 2014-2015 National Comprehensive Cancer Network (NCCN) recommendations
LYMPHEDEMA AND VENOUS STASIS ULCER TREATMENTS	Revised policy to consider the two-phase lymph preparation and drainage therapy device, such as Flexitouch® device, Lympha Press Optimal® or Lympha Press®, medically necessary on a case-by-case basis when standard therapy has failed after a trial of a basic device for one month resulting in persistence of lymphedema or symptoms related to lymphedema, such as swelling, pain and limited range of motion, or if the patient is not able to tolerate a basic device due to pain or wound issues
PHOTOPHORESIS (EXTRACORPOREAL PHOTOCHEMOTHERAPY)	Added as medically necessary, extracorporeal photochemotherapy (ECP) for treatment of lung transplant rejection in individuals who are refractory to or intolerant of standard therapy
ULTRASOUND GUIDANCE FOR PODIATRY AND OTHER JOINT INJECTIONS	Added ultrasound guidance for joint injections as not medically necessary as impacts on health outcomes have not been demonstrated as compared to standard injection techniques
WIRELESS ESOPHAGEAL PH MONITORING	Added titration of protein-pump inhibitors (PPI) dosing in the management of Barrett's esophagus as investigational for wireless esophageal monitoring

Clinical Practice Guidelines

Policy	Change
MAJOR DEPRESSION	Minor updates
SUBSTANCE USE DISORDER	Added a section on evaluating pain patients for risk of opioid abuse or dependence and pain management treatment recommendations

RETIRED MEDICAL POLICIES

Several Health Net medical policies related to radiology procedures have been replaced by MedSolutions clinical guidelines. When viewing individual policies on the Health Net provider website, an indicator displays when MedSolutions guidelines are

applicable. Providers may access the MedSolutions clinical guidelines on the MedSolutions website at www.medsolutions.com/documents/guidelines/guidelines.php.

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

PROVIDER*Update*

CONTRACTUAL | MAY 4, 2015 | UPDATE 15-185 | 1 PAGE

Health Net Access™

Behavioral Health Continuity of Care and Transfer of Treatment

Medically necessary comprehensive behavioral health services are covered for all Health Net Access, Inc. (Health Net) members. Health Net manages the delivery of select services (attention deficit hyperactivity disorder (ADHD), anxiety, depression, and postpartum depression) and facilitates the coordination of care between primary care physicians (PCPs) and behavioral health providers (BHPs). All other behavioral health services are carved out through the Arizona Department of Health Services/Division of Behavioral Health Authority (ADHS/DBHA) – Tribal/Regional Behavioral Health Authority (T/RBHA).

TRANSFER OF CARE FROM PCP TO T/RBHA

Members of any age may be referred to the T/RBHA for screening, evaluation and treatment. Transfer of care to the T/RBHA should occur at the PCP's discretion, member's request or following a sentinel event, such as a suicide attempt or psychiatric hospitalization, or when there are comorbid emotional, physical, sexual, or substance abuse issues.

When transferring a member's care to the T/RBHA, PCPs must use the Behavioral Health Services Referral Form posted on Health Net's provider website at provider.healthnet.com under *Working with Health Net > Quality > AZ Medicaid - Behavioral Health for PCPs > Behavioral Health Referral*. PCPs must complete the form as appropriate, making sure to check the Ongoing Behavioral Health Services box and include the reason for transfer in the Reason for Referral field. When completed, fax the form to the T/RBHA at (844) 424-3975.

Continuity of care is vital when transferring a member's behavioral health care to a T/RBHA provider. PCPs must ensure transfer of records to the T/RBHA provider and that a member has access to sufficient medication until his or her first appointment with the T/RBHA provider.

The member's release of information is required for any communication regarding substance abuse or HIV treatment.

TRANSFER OF CARE FROM T/RBHA TO PCP

If the T/RBHA provider feels the member is clinically stable on his or her current medication regime, and the member has a diagnosis of ADHD, depression or anxiety, a transfer of care back to the Health Net Access PCP may be appropriate. The PCP should continue to prescribe the medication at the dosage at which the member was stabilized, unless there has been a significant change in the member's medical condition.

Providers who have questions or need assistance with the transfer process may contact the Health Net Access behavioral health team via telephone at (602) 794-1401.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

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PROVIDER*Update*

CONTRACTUAL | APRIL 17, 2015 | UPDATE 15-149 | 1 PAGE

Health Net Access™

New Fax Number for EPSDT Submissions

Health Net Access, Inc. has changed the fax number for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) tracking form submission to (866) 684-7363. Providers must use the new fax number immediately when submitting completed Arizona Health Care Cost Containment System (AHCCCS) EPSDT tracking forms.

As a reminder, providers must use only age-appropriate AHCCCS EPSDT tracking forms to document each well-child visit for Health Net Access members under age 21; substitute forms are not acceptable. Providers may utilize an electronic health records system, as long as the electronic documentation includes all fields from the AHCCCS EPSDT tracking forms. Providers must file a copy of the AHCCCS EPSDT tracking form in the member's medical record. Providers may submit a copy of the electronic medical record or AHCCCS EPSDT tracking form to the Health Net Encounters Department via fax at (866) 684-7363 or by mail to:

Health Net Encounters Department
PO Box 419071
Rancho Cordova, CA 95741

Providers must use current AHCCCS EPSDT tracking forms, which are dated April 1, 2014. Current AHCCCS EPSDT tracking forms and completion instructions are available on the AHCCCS website at www.ahcccs.gov/shared/Downloads/Medical PolicyManual/AppendixB.pdf and on the Health Net provider website at provider.healthnet.com in the Provider Library, under *Forms > EPSDT Tracking Forms*.

Providers must complete all sections of the AHCCCS EPSDT tracking form, focusing on frequently missed fields, such as vital signs, height, weight, body mass index (BMI), verbal lead screening, oral health screening, and developmental screening.

ADDITIONAL INFORMATION

If you have questions regarding completion of AHCCCS EPSDT tracking forms, contact the Health Net Access EPSDT coordinator at (602) 794-1539.

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

Online Medical Policies

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THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

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PROVIDER*Update*

CONTRACTUAL | APRIL 20, 2015 | UPDATE 15-160 | 1 PAGE

Health Net Access™

New Primary Care Physician or Medical Group Transfer Form

Health Net has created the new Request for Primary Care Physician (PCP) or Medical Group Change form for providers to request a member's PCP or medical group transfer. Use of this form may more effectively move members from one PCP or medical group to another. Providers may fax or email this completed form as directed on the form to request that a member be reassigned to a new PCP or medical group. Although members may still request transfer via telephone at (888) 788-4408, the new form expedites the transition.

COMPLETING AND SUBMITTING THE FORM

The Request for PCP or Medical Group Change form is available in English and Spanish and is located on Health Net's provider website at provider.healthnet.com in the Provider Library under *Forms > Request for PCP/Medical Group Change Form*.

The requesting provider can easily complete the form with minimal data. Required information from the provider includes the physician's name, address, physician identification (ID) number, and reason for the request. Required information for the member includes the member's name, date of birth and subscriber ID number. Providers must also answer the questions regarding the member's recent hospitalization and treatment.

The form must include contact information for both the provider and member, as well as the member's signature. Providers may submit the completed form via email to shpproviderrequest@healthnet.com, or via fax to:

Attention: Health Net Access
AZ Medicaid Member Services
(818) 676-5161, (818) 676-5491 or (800) 281-2999

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center as listed in the right-hand column.

Provider-Relevant Articles Online

Access informative Online News articles today by logging in to provider.healthnet.com. Select the rotating graphic to read or print articles of interest. Health Net posts new articles each week that cover a variety of topics, such as administrative procedure reminders, quality improvement tips and health care initiatives.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- ● Physicians
- ● Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

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CONTRACTUAL | APRIL 16, 2015 | UPDATE 15-150 | 2 PAGES

Health Net Access™

Screening Patients for Tobacco Use, Alcohol and Other Drug Misuse

Primary care physicians (PCPs) play a pivotal role in the screening and identification of their patients' tobacco use, and alcohol and other drug (AOD) misuse. PCPs often have the first opportunity to recognize, diagnose and initiate treatment for tobacco use or problematic AOD use. PCPs are in a unique position to help their patients stop tobacco use and AOD misuse.

Routine screening is the first step in identifying tobacco use or AOD misuse in the primary care setting. Health Net Access, Inc. recommends annual screening, and not just a one-time, new-patient screening. PCPs should screen patients whenever they have a change in their family, financial or work situations.

AOD SCREENING

According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), alcohol is the third leading risk factor for premature death and disability. Vulnerability to AOD misuse is different from person to person. The following risk factors increase vulnerability:

- Early use of drugs
- Family history
- Behavioral health disorders
- Abuse, neglect or other traumatic experiences in childhood
- Method of use can increase addictive potential

Deciding whether AOD use is problematic is a several-step process. The Substance Abuse and Mental Health Services Administration (SAMHSA) developed the following recommended steps for PCPs:

- Screening using an evidence-based tool
- Brief intervention using risk-level
- Referral to treatment using risk-level

For more information, access the SAMHSA website at www.samhsa.gov.

ADOLESCENT SCREENING

To optimize clinical outcomes, PCPs should categorize adolescent alcohol and substance use problems as developmental, biological, psychological, and social phenomena. Whenever possible, assessment should include information from a variety of sources, including adolescent self-reports (gained through self-monitoring, clinical interview and structured reporting forms), significant others' reports (parents or teachers), psychometric testing, direct observation of the adolescent's behavior, and biological measures. In addition, toxicology screenings can be helpful in verifying teens' reports of recent alcohol or other drug use, and may be mandatory in some treatment settings or among certain populations, such as court-referred juvenile offenders.

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PCPs are encouraged to begin assessments with brief open-ended interviews with adolescents and their parents about presenting problems, specifically chronicity, severity and origins. It is important to focus on problems that the adolescent may have experienced because of substance use, rather than focusing on the frequency, type or quantity of substance use. When the adolescent and his or her parents' descriptions of the presenting problems are contradictory, it is usually best to openly acknowledge these contradictions without siding with the adolescent or his or her parents. Adolescents and parents may request a meeting alone with the PCP, which is up to the PCP if he or she determines it to be potentially necessary and helpful. PCPs should carefully consider and discuss issues related to confidentiality before these meetings occur.

Additional information on treatment of adolescent alcohol use disorders is available online at pubs.niaaa.nih.gov/publications/Social/Module10AAdolescents/Module10A.html.

RESOURCES

Providers may utilize the Health Net Access AOD Toolkit on the Health Net provider website at provider.healthnet.com under *Working with Health Net > Quality >* AZ Medicaid – *Behavioral Health for PCPs > Alcohol and Other Drug (AOD) Toolkit*.

Refer the member to the Maricopa County Regional Behavioral Health for substance abuse treatment by utilizing the ADHS/DBHS Referral for Behavioral Health Services form. The form is available on the Health Net provider website at provider.healthnet.com under *Working with Health Net > Quality >* AZ Medicaid – *Behavioral Health for PCPs > ADHS/DBHS Referral for Behavioral Health Services*, by contacting the behavioral health team at (602) 794-1401 or via email at azbhrbha@healthnet.com.

The following resources are available to members:

- Drugs, Brains, and Behavior: The Science of Addiction – National Institute of Drug Abuse www.drugabuse.gov/sites/default/files/sciofaddiction.pdf
- SAMHSA 24-Hour Help Line at (800) 662-HELP

TOBACCO CESSATION PROGRAM

Health Net Access's Arizona Smokers' Helpline (ASHLine) program offers a variety of options to help members 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.

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

Online Medical Policies

Health Net develops evidence-based medical policies through critical appraisal of current published peer-reviewed medical literature to support providers in determining medical necessity for specific procedures, equipment and services. Medical policies are located on the Health Net provider website at provider.healthnet.com under *Working with Health Net > Clinical > Medical Policies.*

PROVIDER*Update*

CONTRACTUAL | MARCH 31, 2015 | UPDATE 15-128 | 2 PAGES

Health Net Access™

Interest Calculation and Turnaround Times for Health Net Access Claims

This communication provides additional information on interest and turnaround times that were included in provider update 14-577, *Interest Calculation for Health Net Access Claims*, distributed on November 21, 2014.

CLAIMS PAYMENT STANDARDS

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

NON-HOSPITAL CLAIMS

Turnaround Times

Claims for participating providers must be paid or denied within 30 calendar days. Claims for non-participating providers must be paid or denied within 45 calendar days. Computation of turnaround time does not include the first day (receipt date). Mailing days are not included.

Interest

Interest is due on claims not paid within the required turnaround time. The turnaround time is based on the clean claim received date and the interest period begins on the day after payment is due and ends on the day of payment.

Non-participating interest rates are 10 percent per annum (prorated daily). Rates for participating providers are based on the rate published in the Federal Register. The current rate is 2.125 percent, effective January 2015, unless a different rate is stated in the *Provider Participation Agreement (PPA).* Interest is not paid on claims for which no payment is due, or claims that are fully denied.

When Health Net receives the requested additional information for unclean claims that were previously denied due to incomplete information, the interest calculation starts from the date Health Net received the additional information to the completion or check date.

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

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providers following 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.

ADDITIONAL INFORMATION

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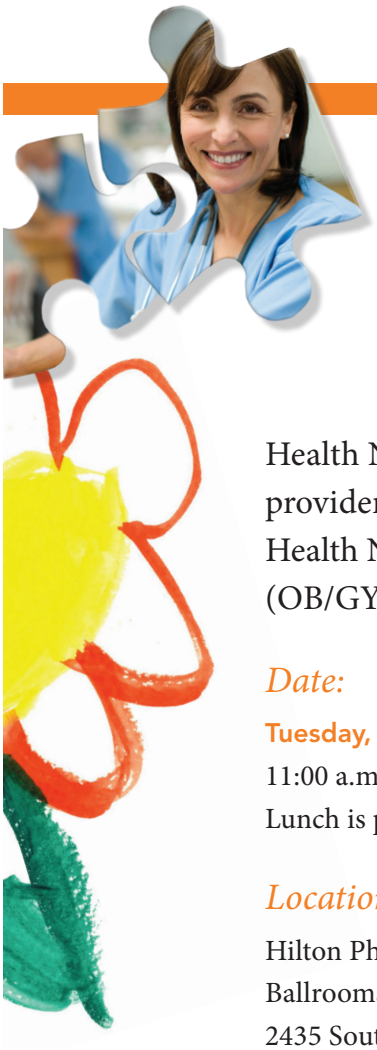
Health Net Access™



Provider *Forum*

Register today for Health Net Access provider training

Health Net Access, Inc. Provider Network Management invites you to an upcoming provider forum for Health Net Access providers. This no-cost training is designed for Health Net Access primary care physicians (PCPs), obstetricians and gynecologists (OB/GYNs), and specialists, as well as their staff, including billing teams.

Date:

Tuesday, April 14, 2015

11:00 a.m. – 2:00 p.m., Mountain time (MT)
Lunch is provided.

Location:

Hilton Phoenix Airport
Ballrooms 2 and 3
2435 South 47th Street
Phoenix, AZ 85034

RSVP:

by Monday, April 6, 2015, via fax
Fax: (602) 794-1803
Availability is limited; register soon!

Who should attend?

- PCPs, OB/GYNs, specialists, staff, billers
- Two representatives per office

Departments presenting include:

- Behavioral Health Services
- Community Solutions
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
  - Arizona State Immunization Information Systems (ASIIS)
- Maternal Child Health (MCH)
- Provider Network Management
- Quality Management/Improvement
  - Arizona Department of Health Services Cancer Prevention
  - American Cancer Society Cancer Prevention

If you are unable to attend the training session, materials will be available on the Health Net provider website at provider.healthnet.com under *Working with Health Net > Regulatory > Health Net Access*, or you may request them from the Health Net Quality Improvement Department via email at AHCCCS_Notification@healthnet.com.

Please complete the registration information below and fax it to the number listed above.

Attendee Name (please print)	*Physician/Practice Name & Tax ID*	*Specialty*	*Telephone*

15-122 (3/15)

PROVIDER*Update*

CONTRACTUAL | MARCH 27, 2015 | UPDATE 15-110 | 2 PAGES

Health Net Access™

Address Changes and Enrollment Information for ERA and EFT

This provider update provides information on address changes for submitting Health Net Access, Inc. (AHCCCS) provider claim disputes and provider state fair hearing requests, and information on enrolling for electronic remittance advice (ERA) and electronic funds transfer (EFT).

NEW ADDRESSES FOR SUBMITTING CLAIM DISPUTES AND STATE FAIR HEARING REQUESTS

Providers should now send any claim disputes or state fair hearing requests to the following new addresses:

Provider Claim Dispute Requests

Health Net Access Provider Disputes
1230 West Washington Street, Suite 401
Tempe, AZ 85281

Provider State Fair Hearing Requests

Health Net Access State Fair Hearing
1230 West Washington Street, Suite 401
Tempe, AZ 85281

ERA

ERA provides details on multiple claims and helps improve business office workflow by allowing the adjudicated claim information to be automatically posted to accounts receivable systems. Health Net sends an ERA to any provider who registers with an approved clearinghouse. ERA complies with Health Insurance Portability and Accountability Act (HIPAA) 835 requirements making it consistent with other payers and is acceptable nationwide.

Enrolling for ERA

Providers have the option to submit the enrollment form online or to download the form and send to Health Net via email or fax.

Online enrollment is available on Health Net's provider website at provider.healthnet.com under *Transactions* > *Claims* > *Download* > *Submit ERA Enrollment Online*.

If the provider prefers to email or fax the ERA enrollment form, the form is available on Health Net's provider website at provider.healthnet.com under *Transactions* > *Claims* > *Download* > *Print or download pdf*. Complete the form and submit it to Health Net via email at edi.support@healthnet.com or by secure fax to (800) 677-4147, Attention: EDI Business. Providers must also enroll with their clearinghouse.

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EFT

EFT automates the distribution of funds into accounts using automated clearinghouse processing to reconcile accounts receivable, which provides significant savings in check processing fees. Before EFT, providers were required to open the mail, pull the check, enter the data into their systems, get the checks to the bank, wait for them to clear, reconcile books, and more. EFT is safe, secure, efficient, and less expensive than paper check payments and collections.

Enrolling for EFT

Providers have the option to submit the enrollment form online or to download the form and send to Health Net via email or fax.

Online enrollment is available on Health Net's provider website at provider.healthnet.com under *Transactions* > *Claims* > *Download* > *Submit EFT Enrollment Online*.

If the provider prefers to email or fax the EFT enrollment form, the form is available on Health Net's provider website at provider.healthnet.com under *Transactions* > *Claims* > *Download* > *Print or download pdf*. Complete the form and submit it, along with a voided check, to Health Net via email at edi.support@healthnet.com or by secure fax to (800) 677-4147, Attention: EDI Business.

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

Online Medical Policies

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PROVIDER*Update*

REGULATORY | MARCH 24, 2015 | UPDATE 15-103 | 2 PAGES

Health Net Access™

Health Net Access Fraud, Waste and Abuse Reporting and Training

This update includes important information on the federal False Claims Act (FCA), instructions on how to report suspected fraud, waste and abuse (FWA) and provider training requirements for Health Net Access, Inc. (AHCCCS).

FEDERAL FALSE CLAIMS ACT

In accordance with the FCA, the following acts are unlawful:

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

The FCA is important because it:

- Outlines the rights of consumers and providers to take action to combat fraud on behalf of the government
- Expands the scope of fraud beyond those who knowingly intend to commit it
- Provides protections to those who bring the false claims to light
- Established stringent penalties for those found guilty

FRAUD, WASTE AND ABUSE

Health care FWA contributes to the rising cost of health insurance, reduces the amount of funds available to pay honest providers, and reduces the available funds used to provide essential medical services for Medicaid patients. Health Net investigates allegations of 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, which is 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's Code of Business Conduct and Ethics, or accessing personal information or protected health information (PHI) without authorization

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REPORTING FRAUD, WASTE, ABUSE, OR VIOLATIONS OF STANDARDS OF CONDUCT

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

To report suspected FWA, contact Health Net via mail or telephone as listed below:

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

To report potential or actual noncompliance or ethical concerns, contact Health Net via mail or telephone as listed below:

Health Net Access Compliance Officer
Gay Ann Williams
Mail Stop: AZ-900-04-23
1230 West Washington Street, Suite 401
Tempe, AZ 85281
Health Net's Integrity Line: (888) 866-1366

FWA TRAINING

Arizona Health Care Cost Containment System (AHCCCS) has launched the Fraud Awareness for Providers Training through the AHCCCS website at www.azahcccs.gov/multimedia/CBT/healthplanproviderfraud/healthplanproviderfraudfs.htm. Health Net Access participating providers can use this training module to satisfy the AHCCCS training requirement for educating staff and providers on fraud and abuse.

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

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CONTRACTUAL | MARCH 24, 2015 | UPDATE 15-106 | 1 PAGE

Health Net Access™

Health Net Access Contracting Hospitals

The following hospitals are contracting with Health Net Access, Inc. Providers must refer Health Net Access members to these participating hospitals for services, except in emergency situations.

Parent Group	Hospitals
ABRAZO	• Arrowhead Community Hospital • Maryvale Hospital • Paradise Valley Hospital • Phoenix Baptist Hospital • West Valley Hospital
BANNER HEALTH	• Banner Baywood Medical Center • Banner Boswell Medical Center • Banner Del E. Web Medical Center • Banner Desert Medical Center • Banner Estrella Medical Center • Banner Gateway Medical Center • Banner Goldfield Medical Center • Banner Good Samaritan Medical Center • Banner Heart Hospital • Banner Ironwood Medical Center • Banner Page Hospital • Banner Thunderbird Medical Center
DIGNITY	• Chandler Regional Medical Center • Mercy Gilbert Medical Center • St. Joseph's • St. Joseph's Westgate Medical Center
IASIS	• Mountain Vista Medical Center • St. Luke's Medical Center
JC LINCOLN	• John C. Lincoln Hospital – Deer Valley • John C. Lincoln Hospital – North Mountain
MARICOPA INTEGRATED HEALTH SYSTEMS	• Maricopa Medical Center

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CONTRACTUAL | MARCH 23, 2015 | UPDATE 15-107 | 1 PAGE

Health Net Access™

New Procedure Code for Application of Fluoride Varnish

Effective April 1, 2015, the procedure code for reporting fluoride varnish application for Health Net Access, Inc. (AHCCCS) claims is changing from HCPCS[1] code D1206 to CPT[2] code 99188.

Beginning with dates of service April 1, 2015, and after, physicians, physician assistants (PAs), registered nurse practitioners (NPs), and osteopaths must use CPT code 99188, application of topical fluoride varnish by a physician or other qualified health care professional, to report fluoride varnish application. Dentists should continue to use HCPCS code D1206, topical application of fluoride varnish.

Prior to April 1, 2015, physicians, PAs, registered NPs, and osteopaths may report fluoride varnish application using either CPT code 99188 or HCPCS code D1206.

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

[1] HCPCS code descriptions were taken from the CMS HCPCS Code Sets.

[2] CPT codes were taken from the 2014 American Medical Association CPT Code Handbook.

Online Medical Policies

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PROVIDER*Update*

CONTRACTUAL | MARCH 18, 2015 | UPDATE 15-090 | 1 PAGE

Health Net Access™

Behavioral Health Care Treatment and Resources

Primary care physicians (PCPs) may provide medication management services, such as medication monitoring, prescriptions, laboratory, and other diagnostic tests necessary for diagnosis and treatment of select behavioral health disorders. Select behavioral health disorders include anxiety, mild depression, postpartum depression, and attention deficit hyperactivity disorder (ADHD).

PCPs may use the Arizona Health Care Cost Containment System (AHCCCS) toolkits for best practices in treating the following disorders:

- Adult ADHD management
- Adult anxiety management
- Adult depression management
- Childhood and adolescent ADHD management
- Childhood and adolescent anxiety management
- Childhood and adolescent depression management
- Postpartum depression management

The toolkits include assessment tools, scoring instructions and recommended medication lists, and are available on the Health Net provider website at provider.healthnet.com under *Working with Health Net > Quality > Behavioral Health for PCPs,* or upon request by contacting the Health Net Access behavioral health team at (602) 794-1401.

PCP REFERRALS

PCPs may refer members who need behavioral health services outside the scope of the PCP's practice, or members identified as having substance abuse issues to the Regional Behavioral Health Authority (RBHA), or Tribal/Regional Behavioral Health Authority (T/RBHA) for members who are American Indians, at any time.

PCPs may refer members by calling (800) 564-5465 or by completing and faxing the Behavioral Health Form at (844) 424-3975. The form is located on the Health Net provider website at provider.healthnet.com under *Working with Health Net > Quality > Behavioral Health for PCPs*.

PCPs who have questions or need assistance with the referral process should contact the Health Net Access behavioral health team at (602) 794-1401.

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PROVIDER*Update*

CONTRACTUAL | MARCH 10, 2015 | UPDATE 15-084 | 1 PAGE

Health Net Access™

Genetic Testing Prior Authorization Requirement Reminder

As a reminder, as stated in Health Net's *Provider Participation Agreements (PPAs)* and provider update 14-518, *Prior Authorization Requirement Changes*, distributed October 23, 2014, all genetic testing services require prior authorization. Obtaining prior authorization is the provider's responsibility. The member must not be billed if the provider fails to obtain prior authorization prior to performing services.

PROVIDER PARTICIPATION AGREEMENTS

Health Net's *PPAs* have provisions that state:

> "… In the event Provider knowingly refers a Beneficiary to a non-Participating Provider without a Referral or without Prior Authorization when either or both are required by a Benefit Program, Provider agrees to be responsible for payment of claims incurred for the unauthorized Covered Service, and Provider agrees to hold harmless the Beneficiary for such claims. Provider shall use best efforts to assist Health Net or Payor in their efforts to contract with Provider's Facility-based physicians. Health Net and Payor require that the most cost effective, qualified Participating Provider be utilized."

PRIOR AUTHORIZATION REQUIREMENTS

Prior authorization requirements are available on the Health Net provider website at provider.healthnet.com both pre-log in and post-log in as described below.

Pre-Log In

Requirements are posted under *Working With Health Net > Policies for Non-Contracting Providers > Services Requiring Prior Authorization* (under Additional Resources).

Post-Log In

Requirements are posted in two places:

- Under *Working With Health Net > Contractual > Services Requiring Prior Authorization*
- In the Health Net Provider Library under *Operations Manuals > Prior Authorization*. Information regarding Health Net's prior authorization policies and procedures is also available in the operations manuals

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more. If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

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NEWS & ANNOUNCEMENTS | FEBRUARY 20, 2015 | UPDATE 15-065 | 1 PAGE

Health Net Access™

2015 Provider Teleconferences

Health Net is offering a variety of educational teleconferences in 2015 to physicians, case managers, nurses, and other staff who work with Health Net members. Health Net offers continuing education hours for nurses[1] for all teleconferences, and St. Joseph's Hospital and Medical Center offers continuing medical education (CME)[2] credits for all teleconferences. Teleconferences are scheduled from 12:00 to 1:00 p.m. Pacific time (PT) unless otherwise specified below, and topics and dates, which are subject to change, are as follows:

Topic	Date
Special Needs Plan (SNP) Model of Care (10:00 to 11:00 a.m.)	February 25, 2015
Identifying and Treating Substance Abuse Disorders in the Primary Care Setting	April 22, 2015
Importance of Physical Activity	June 17, 2015
Cancer Prevention and Screening	July 22, 2015
Healthcare Effectiveness Data and Information Set (HEDIS®[3]) Best Practices and Update	August 19, 2015
Prevention and Immunization	October 19, 2015
Quality Outcomes	December 9, 2015

Some of the topics are linked to the Centers for Medicare and Medicaid Services (CMS) Five-Star Quality Rating System measures. Health Net encourages provider attendance and engagement at these educational teleconferences to address health care gaps, achieve better patient outcomes and patient satisfaction.

REGISTRATION

Providers can register for these teleconferences via email to cqi_medicare@healthnet.com. Health Net sends a confirmation email with call-in information and meeting materials to registered participants prior to the teleconference. After the teleconference, attendees are sent a survey and instructions for obtaining CEUs and CMEs.

[1] Provider-approved by the California Board of Registered Nursing, provider number CEP 13156, for 1 or 1.5 contact hours.

[2] This activity has been planned and implemented in accordance with the essential areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of St. Joseph's Hospital and Medical Center and Health Net. St. Joseph's Hospital and Medical Center is accredited by the ACCME to provide continuing medical education for physicians. St. Joseph's Hospital and Medical Center designates this live activity for a maximum of 1 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

[3] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- ● Physicians
- ● Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

PROVIDER SERVICES

az_internetproviderinquiries@healthnet.com
(888) 788-4408
www.healthnet.com

NATIONAL PROVIDER COMMUNICATIONS

provider.communications@healthnet.com
fax (800) 937-6086

Health Net Access, Inc.
1230 W. Washington St., Suite 401
Tempe, Arizona 85281
602.794.1400
800.289.2818
www.healthnet.com

February 17, 2015

<Entity Name>
<First name> <Last name>, <Title> *or* Administrator
<Address>
<City>, <State> <ZIP>

Dear <Title>. <Last Name> *or* Administrator:

Enclosed is an amendment that updates your *Provider Participation Agreement* (*PPA*), effective January 1, 2015. This amendment ensures your *PPA* is compliant with the Arizona Health Care Cost Containment System (AHCCCS) Minimum Subcontract Provisions (MSPs), which are available on the AHCCCS website at www.azahcccs.gov/commercial/MinimumSubcontractProvisions.aspx. Effective with this amendment, any future changes to the MSPs automatically amend your *PPA*.

Please file this amendment with your copy of the *PPA*. No further action is necessary on your part, unless you choose not to accept this amendment. If you decline to accept the amendment, please notify Health Net in writing within 30 calendar days of this notice to:

Health Net
Attention: Provider Network Management
1230 W. Washington St., Ste 401
Tempe, AZ 85281

Thank you for participating in Health Net Access. We appreciate your service to our members and look forward to your continued participation. If you have questions regarding the enclosed amendment, contact the Health Net Access Provider Services Center at (888) 788-4408.

Sincerely,

Jacqueline Thames
Director, Provider Network Management

Enclosure

15-034

AMENDMENT

TO THE HEALTH NET PROVIDER PARTICIPATION AGREEMENT

This Amendment modifies the PROVIDER PARTICIPATION AGREEMENT in effect on or before January 1, 2015 (hereinafter "Agreement") by and between **Health Net of Arizona, Inc. on behalf of itself and the subsidiaries and affiliates of Health Net, Inc., including Health Net Access, Inc.** (collectively, "Health Net") and Provider:

WHEREAS, Health Net contracts with the Arizona Health Care Cost Containment System (AHCCCS), the Arizona State Medicaid Agency, to provide covered services to AHCCCS beneficiaries/members enrolled with Health Net through an agreement between AHCCCS and Health Net Access, Inc.;

WHEREAS, in order to meet AHCCCS contracting requirements, Health Net must ensure AHCCCS subcontracting provisions are cascaded to Provider when updated by AHCCCS;

WHEREAS, referring to the AHCCCS website provides the quickest and most efficient method to ensure Provider has access to the most current and complete regulatory requirements.

NOW, THEREFORE, pursuant to Section 7.1 of the Agreement, the parties hereby amend the Agreement, as of the Amendment Effective Date, as follows:

1) **Addendum F, MEDICAID PROVISIONS, ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS**), ***Minimum Subcontract Provisions*** shall be deleted in its entirety and replaced as follows:

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

Minimum Subcontract Provisions

The provisions referred to by AHCCCS as "Minimum Subcontract Provisions", including all subsequent updates published by AHCCCS, apply to Provider and are fully set forth in the following internet link:

http://www.azahcccs.gov/commercial/MinimumSubcontractProvisions.aspx

2) This Amendment shall be deemed to be part of the Agreement and, as modified in accordance herewith, the Agreement is hereby affirmed and declared in full force and effect. This Amendment supersedes and replaces any conflicting provisions contained in the Agreement, leaving all other provisions of the Agreement unaffected.

Amendment Effective Date: January 1, 2015

PROVIDER*Update*

CONTRACTUAL | FEBRUARY 11, 2015 | UPDATE 15-033 | 1 PAGE

Health Net Access™

Amendment to Ensure Compliance with Minimum Subcontract Provisions

This communication notifies providers of Health Net's intent to amend the terms of their *Provider Participation Agreements* (*PPAs*) pursuant to changes in regulation. The amendment ensures that providers' *PPAs* remain compliant with the Arizona Health Care Cost Containment System (AHCCCS) Minimum Subcontract Provisions, which are available on the AHCCCS website at www.azahcccs.gov/commercial/MinimumSubcontractProvisions.aspx.

In February 2015, Health Net is sending a letter and amendment to Health Net Access participating providers. No further action is required by the provider unless he or she chooses not to accept the amendment. Providers must notify Health Net in writing within 30 calendar days of receiving the amendment if he or she declines to accept the amendment.

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

Discover Helpful Tools to Support Your Office

The Provider Library online at provider.healthnet.com allows participating providers to quickly access pertinent information to assist in their everyday interaction with Health Net. The Provider Library includes operations manuals, communications (updates and letters), Online News articles, forms, Health Net contact information, and more.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- Physicians
- Medical Groups/IPAs
- Hospitals
- Ancillary Providers

PROVIDER SERVICES

az_internetproviderinquiries@healthnet.com
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provider.communications@healthnet.com
fax (800) 937-6086

PROVIDER*Update*

CONTRACTUAL | JANUARY 30, 2015 | UPDATE 15-024 | 3 PAGES

Health Net Access™

Medical Policies – 4th Quarter 2014

This provider update includes a listing of updated Health Net behavioral health and medical policies approved by the Health Net National Medical Advisory Council (MAC) in the fourth quarter of 2014. For a complete description of new and updated medical policies, visit the Health Net provider website at provider.healthnet.com and select *Working with Health Net > Clinical > Medical Policies*.

PURPOSE OF HEALTH NET MEDICAL POLICIES

Medical policies provide guidelines for determining medical necessity for specific procedures, equipment and services. All services must be medically necessary to be eligible for benefit coverage, unless otherwise defined in the member's benefits contract. The determination for coverage is also based on all of the terms of the individual member's benefits contract, including, but not limited to, eligibility at the time of service and description of covered benefits, limitations and exclusions. In some cases, legal or regulatory mandate requirements may be applicable and may prevail over medical policy. To the extent there are any conflicts between medical policy guidelines and applicable benefit contract language, the benefit contract language prevails. Medical policy is not intended to override the *Member Handbook* or the health insurance policy that defines the member's benefits, nor is it intended to provide medical advice or dictate to providers how to practice. If required, prior authorization must be obtained before services are rendered.

Behavioral Health Updates

Policy	Policy Statement
AUTISM SPECTRUM DISORDERS	Added reference to the American Academy of Child and Adolescent Psychiatry (AACAP) 2014 updated practice parameters and 2015 Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5®). Added Wood's lamp exam of the skin and chromosomal microarray genetic testing to the medical evaluation section. Condensed sections on applied behavioral analysis (ABA) therapy
CLINICAL PRACTICE GUIDELINE FOR ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) IN CHILDREN	No major changes. Added that quantitative electroencephalogram (EEG) studies have demonstrated some efficacy in diagnosis, but appear to have decreased accuracy as the patient ages. EEG is not currently a generally accepted method to use for diagnosis. It may have some prognostic ability regarding potential for efficacy of treatment, but not in determining treatment intervention. It is not considered standard of care at this time

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

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Updated Policies

Medical Policy	Change
BARIATRIC SURGERY	Removed requirement for specific chart notes to allow for any type of documentation of weight loss attempts
CARDIAC DEFIBRILLATOR, IMPLANTABLE (ICD)	The American Heart Association (AHA) and the American College of Cardiology (ACC) revised medical necessity criteria for ischemic and non-ischemic cardiomyopathy from six months to three months of guideline-directed medical therapy (GDMT). Added ICD as medically necessary for primary prevention of sudden cardiac death in patients with non-ischemic dilated cardiomyopathy or ischemic heart disease at least 40 days post-myocardial infarction (MI)
CHELATION THERAPY	Added superconducting quantum interference device (SQUID) for the measurement of hepatic iron concentration when there is chronic iron overload, as investigational. Availability and utility are limited with SQUID, as it measures only liver and spleen iron content, and cannot detect cellular liver damage, or evaluate myocardial iron; it may underestimate liver iron concentration (LIC). Codes updated
COMPUTED TOMOGRAPHY ANGIOGRAPHY (CTA) OF CORONARY ARTERIES	Additional indications for CTA were added under both medically necessary and not medically necessary sections of the policy statement
COSMETIC AND RECONSTRUCTIVE SURGERY	Added procedures that are on the 2015 prior authorization list, such as vermilionectomy, vestibuloplasty, additional liposuction (not limited to the abdomen), and various CPT codes
DNA ANALYSIS OF STOOL TO SCREEN FOR COLORECTAL CANCER	Removed note in policy statement regarding PreGen-26™ and PreGen-Plus™ (information is noted in scientific rationale). Added Cologuard® as an example of a stool-based Food and Drug Administration (FDA) approved test for screening for colorectal cancer. No change to policy; testing remains investigational
FECAL BACTERIOTHERAPY	Revised policy to consider this medically necessary for *Clostridium difficile* infection (CDI) when criteria are met: • At least three episodes of mild to moderate CDI and failure of a six- to eight-week taper with vancomycin with or without an alternative antibiotic, such as rifaximin, nitazoxanide • At least two episodes of severe CDI resulting in hospitalization and associated significant morbidity • Moderate CDI not responding to standard therapy (vancomycin) for at least one week • Severe fulminant *C. difficile* colitis with no response to standard therapy after 48 hours
GENETIC COUNSELING	Added genetic counseling and fragile X premutation carrier screening as medically necessary for women with a family history of fragile X-related disorders, unexplained mental retardation or developmental delay, autism, or premature ovarian insufficiency. This is consistent with American Congress of Obstetricians and Gynecologists (ACOG) recommendations

Updated Policies, continued

Medical Policy	Change
GENETIC TESTING FOR CYSTIC FIBROSIS	Clarified that carrier testing may be offered to all patients as recommended by ACOG and the American College of Medical Genetics, and removed statement that indicated population testing and newborn testing may not be medically necessary
GENETIC TESTING INDICATIONS	Added section on carrier testing for various genetic disorders in individuals of Eastern European Jewish descent (Ashkenazi Jews) and individuals of African, Mediterranean and Southeast Asian heritage
IMPLANTABLE MINIATURE TELESCOPE	Revised age requirement from 75 to 65 based on recent FDA approval and added contraindications
OCCIPITAL NERVE STIMULATION FOR HEADACHES	Revised to consider occipital nerve stimulation medically necessary on a case-by-case basis when refractory to conservative treatment and a pre-permanent implantation trial is successful
OUTPATIENT CARDIAC REHABILITATION	Added Ornish cardiac rehabilitation as investigational for commercial members since it does not offer any additional improvements over standard outpatient cardiac rehabilitation
PHYSICAL AND OCCUPATIONAL THERAPY	Under documentation requirements, clarified that re-evaluation should occur every three months
PROTON BEAM RADIOTHERAPY	Added retinoblastoma to number five, under medically necessary indications for proton beam radiotherapy, as another example of tumors that are adjacent to critical structures
SACROILIAC JOINT FUSION	Sacroiliac joint fusion procedures may be indicated on a case-by-case basis as a last line therapy when refractory to conservative treatment, for stabilization of a traumatic, severe disruption or fracture of the pelvic ring, as an adjunct to sacrectomy or partial sacrectomy for treatment of sacral tumors, or as an adjunct to the medical treatment of sacroiliac joint infection or sepsis, such as osteomyelitis or pyogenic sacroilitis
SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING (SCODI)	Added as medically necessary: SCODI as a baseline prior to starting chloroquine (Aralen®) or hydroxychloroquine (Plaquenil®) or to detect retinal changes resulting from the use of these medications. Added section to policy to clarify when SCODI would be medically necessary to evaluate the anterior segment of eye. Revised note regarding frequency of SCODI, noting that only two exams per eye per year should be required to manage patients who have glaucoma or are suspected of having glaucoma
SEPTOPLASTY	Removed criteria that required documentation of specific percentages of nasal obstruction

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

Health Net Access, Inc.
1230 W. Washington St., Suite 401
Tempe, Arizona 85281
602.794.1400
800.289.2818
www.healthnet.com

January 30, 2015

<Entity Name>
<First name> <Last name>, <Title> *or* Administrator
<Address>
<City>, <State> <ZIP>

Dear <Title>. <Last Name> *or* Administrator:

We would like to assess Health Net Access providers' satisfaction with Health Net's business processes and procedures. Accordingly, enclosed with this letter is a brief survey for your completion. We ask that you take a few minutes to complete it, as your responses will greatly assist us in developing and improving practices to better serve Health Net Access providers. If appropriate, please feel free to discuss the survey with others in your office or facility who interact directly with Health Net to ensure you represent all views and opinions in your response.

Please complete this survey in its entirety by **February 15, 2015**, and fax back to Health Net Provider Network Management at (602) 794-1803.

If you have any questions about the Health Net Access Provider Satisfaction Survey, please contact Health Net Provider Services at (888) 788-4408.

Sincerely,

Karen Ellington

Karen Ellington
Provider Relations and Contracting Manager, Provider Network Management

Enclosure

15-032

Health Net Access™

Health Net Access
Provider Satisfaction Survey

Please complete and return to Health Net Provider Network Management via fax at (602) 794-1803 by February 15, 2015.

Provider office

1. What is your practice type?

- ☐ Primary care
- ☐ OB/GYN
- ☐ Specialist
- ☐ Dental

2. What is your role within the practice?

- ☐ Physician
- ☐ Office manager
- ☐ Front office staff
- ☐ Nurse
- ☐ Other office staff

Please complete this evaluation by circling your response below:

	Excellent	Good	Fair	Poor
Claims				
Timeliness of claims processing	**4**	**3**	**2**	**1**
Accuracy of claims processing	**4**	**3**	**2**	**1**
Courtesy of claims customer service representative	**4**	**3**	**2**	**1**
Accurate answers to your claims questions	**4**	**3**	**2**	**1**
Prior Authorization (PA)				
PAs completed in a timely manner	**4**	**3**	**2**	**1**
Courtesy of PA staff when you call	**4**	**3**	**2**	**1**
Accurate answers to your PA questions	**4**	**3**	**2**	**1**
Provider Network Management (PNM)				
Timeliness of service from PNM representative	**4**	**3**	**2**	**1**
Courtesy of PNM representative	**4**	**3**	**2**	**1**
Communication clarity from PNM representative	**4**	**3**	**2**	**1**

Health Net Access™

Health Net Access
Provider Satisfaction Survey

Provider communications

1. **Is the volume of provider updates that your office receives from Health Net:**

   ☐ Too much
   ☐ Adequate
   ☐ Too little

2. **How useful do you find the provider updates?**

   ☐ Very useful
   ☐ Somewhat useful
   ☐ Not useful

3. **Are the communications you receive applicable to your office/specialty?**

   ☐ Yes
   ☐ Sometimes
   ☐ No

   Comments:
   _____
   _____
   _____

4. **Please rate your satisfaction with the *usefulness* of feedback/reports from the following practitioners and providers for patients in your care:**

	Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied	N/A
Primary care physicians	☐	☐	☐	☐	☐	☐
Specialists	☐	☐	☐	☐	☐	☐
Psychiatrist/behavioral health specialists	☐	☐	☐	☐	☐	☐

If you are having an issue with a specialty, please list that specialty: _____

5. **If you have interacted with MHN, Health Net's behavioral health division, in the last 12 months, please rate your level of satisfaction:**

	Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied	Did not use MHN
Ease of the referral	☐	☐	☐	☐	☐	☐

Health Net Access™

Health Net Access
Provider Satisfaction Survey

Access and availability

1. Please rate your satisfaction with access and/or availability to the services listed to ensure patients receive timely care as appropriate for their condition:

	Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied	N/A
Referrals and authorization process	☐	☐	☐	☐	☐	☐
Access to urgent care	☐	☐	☐	☐	☐	☐
Access to non-urgent ancillary diagnostic and treatment services	☐	☐	☐	☐	☐	☐

Network

2. Please rate your satisfaction with the Health Net Access network:

	Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied	N/A
Number of specialists	☐	☐	☐	☐	☐	☐
Quality of specialists	☐	☐	☐	☐	☐	☐
Number of ancillary providers	☐	☐	☐	☐	☐	☐
Quality of ancillary providers	☐	☐	☐	☐	☐	☐
Number of contracted hospitals	☐	☐	☐	☐	☐	☐
Quality of contracted hospitals	☐	☐	☐	☐	☐	☐
Number of behavioral health providers	☐	☐	☐	☐	☐	☐
Quality of behavioral health providers	☐	☐	☐	☐	☐	☐

Provider Network Management

3. Please rate your level of satisfaction with Provider Network Management staff:

	Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied	Never used
Returning your telephone calls	☐	☐	☐	☐	☐	☐
Courtesy and professionalism	☐	☐	☐	☐	☐	☐
Problem solving	☐	☐	☐	☐	☐	☐

Please comment on the type of information you prefer and/or find beneficial when Provider Network Management staff visit your office.

_____
_____
_____

Health Net Access™

Health Net Access
Provider Satisfaction Survey

Overall satisfaction and loyalty

4. Please rate your overall experience with Health Net Access:

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
I am completely satisfied with Health Net Access	☐	☐	☐	☐	☐
I would recommend Health Net Access to my patients	☐	☐	☐	☐	☐
I would recommend Health Net Access to other physicians	☐	☐	☐	☐	☐
I see my relationship with Health Net Access continuing long term	☐	☐	☐	☐	☐
Health Net Access is a committed partner in providing quality care	☐	☐	☐	☐	☐

What else would you like to communicate about Health Net Access?

_____
_____
_____

Thank you for your participation.

PROVIDER*Update*

CONTRACTUAL | DECEMBER 18, 2014 | UPDATE 14-612 | 1 PAGE

Health Net Access™

EPSDT Tracking Form Submission to Health Net Encounter Department

All Health Net participating providers who provide preventive health care services to Health Net Access members under age 21 must use the current age-appropriate Early and Periodic Screening, Diagnosis and Treatment (EPSDT) tracking forms to document well-child visits. Providers must sign the completed EPSDT tracking forms and place them in the member's medical record.

Providers must also submit a copy of the completed, signed EPSDT tracking form to Health Net's Encounter Department. Effective January 1, 2015, providers may no longer submit a copy of the member's medical record to Health Net's Encounter Department. Only copies of the completed and signed age-appropriate EPSDT tracking forms are acceptable.

Providers may submit the EPSDT tracking forms to the Health Net Encounter Department via fax at (916) 935-4476 or by mail to:

Health Net Encounter Department
PO Box 419071
Rancho Cordova, CA 95741

Current EPSDT tracking forms are available on the Arizona Health Care Cost Containment System (AHCCCS) website at www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixB.pdf and on the Health Net provider website at provider.healthnet.com in the Provider Library, under *Forms > EPSDT Tracking Forms.*

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

Take Advantage of Health Net's Online Tools

Visit Health Net's provider portal directly at provider.healthnet.com. Once logged in, quickly find and verify member eligibility, copayments, prior authorization requirements, and other plan details under Patient Information for a selected member. View his or her transaction status under Patient History to find what you need, when you need it.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- ● Physicians
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PROVIDER*Update*

CONTRACTUAL | DECEMBER 17, 2014 | UPDATE 14-613 | 2 PAGES

Health Net Access™

Annual EPSDT Program Reminders

As a reminder, Health Net Access providers must adhere to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program requirements, which are outlined in this communication. For the most current and accurate information, Health Net recommends that providers regularly visit the Provider Library on the Health Net provider website at provider.healthnet.com.

SCREENINGS

A well child visit is synonymous with an EPSDT visit and includes all EPSDT screenings and services described in the current Arizona Health Care Cost Containment System (AHCCCS) EPSDT Periodicity Schedule and the AHCCCS Dental Periodicity Schedule. EPSDT screenings must be reported on age-appropriate EPSDT tracking forms to document well-child visits. Current EPSDT tracking forms and completion instructions are available on the AHCCCS website at www.ahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixB.pdf and on the Health Net provider website at provider.healthnet.com in the Provider Library, under *Forms* > *EPSDT Tracking Forms*.

Providers may utilize an electronic health record system, as long as the electronic documentation includes all elements from the AHCCCS EPSDT tracking forms. Providers must file a copy of the EPSDT tracking form in the member's medical record.

Body Mass Index

Providers must assess body mass index (BMI) for members ages 24 months and older, and document results on the age-appropriate EPSDT tracking form. Refer to the Centers for Disease Control and Prevention (CDC) website at www.cdc.gov/growthcharts for BMI and growth chart resources. Providers must refer members with elevated BMI, based on CDC guidelines, to Health Net's Case Management Department for follow-up.

Verbal Lead Screening

Providers must conduct verbal lead screening for risk of lead exposure during each EPSDT visit with members ages six months to six years, and document results on the EPSDT tracking forms.

Blood Lead Screening

EPSDT covers blood lead screening. All members must receive a blood lead screening at ages 12 months and 24 months. Members between ages 36 and 72 months must receive a blood lead test if they have not previously been screened for lead poising. Providers must document results of a blood lead screening on the EPSDT tracking form.

IMMUNIZATIONS

The EPSDT program covers all child and adolescent immunizations. Participating providers must coordinate with the Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) program. Providers must enroll or re-enroll annually with the

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

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VFC program in order to participate. Immunizations must be provided according to the Advisory Committee on Immunization Practices (ACIP) recommended schedule. Health Net does not reimburse participating providers for vaccines covered by the VFC program. Health Net reimburses for the administration of these immunizations only.

Arizona state law requires providers to report all immunizations given to children under age 19 at least monthly to the ADHS Immunization Registry; however, it is recommended that high-volume immunization providers report more frequently. Providers may enter all immunizations online at asiis.azdhs.gov or mail the appropriate completed form located at asiis.azdhs.gov/main.jsp to:

Arizona State Immunization Information System (ASIIS)
150 N. 18th Avenue, #120
Phoenix, AZ 85007

NUTRITIONAL ASSESSMENT

Health Net covers the assessment of a Health Net Access member's nutritional status as part of the EPSDT program when deemed necessary by the member's primary care physician (PCP). This includes EPSDT-eligible members who are underweight 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 it to the Health Net Prior Authorization Department at (855) 764-8513. Prior authorization is not required when the nutritional assessment is ordered by the member's PCP.

FLUORIDE VARNISH

Certified PCPs should apply fluoride varnish starting from the first tooth eruption at age six months to age two. Coverage is limited to services provided in the PCP's office and once every six months, during an EPSDT visit for children who are age six months with at least one tooth erupted, with recurrent applications up to age two. After age two, children must visit a dentist for fluoride varnish.

For reimbursement, PCPs must submit proof of training and certification from AHCCCS-approved organizations, to the Council for Affordable and Quality Healthcare (CAQH) at www.caqh.org.

MISSED APPOINTMENT

Providers are expected to follow up with members who miss or cancel appointments and notify Health Net Access when a member has missed or cancelled three or more visits. Providers may utilize the Health Net Access Missed Appointment/No Show Log, available on the Health Net provider website at provider.healthnet.com in the Provider Library under *Forms.* Providers must place a copy of any follow-up attempts in the member's medical record. Health Net assists providers with Health Net Access members who fail to show up for appointments. Health Net will contact members' parents or guardians to remind them about the importance of a well-child visit and required immunizations.

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

Provider-Relevant Articles Online

Access informative Online News articles today by logging in to provider.healthnet.com. Select the rotating graphic to read or print the articles of interest. Health Net posts new articles each week that cover a variety of topics, such as health plan updates, administrative procedure reminders, quality improvement tips, and health care initiatives.

PROVIDER*Update*

REGULATORY | DECEMBER 10, 2014 | UPDATE 14-596 | 1 PAGE

Health Net Access™

Criteria for PCP Panel Closure

In accordance with Arizona Health Care Cost Containment System (AHCCCS) requirements, the Health Net Access (AHCCCS) plan collects quarterly data to determine whether a primary care physician's (PCP's) panel is closed to new members. PCP panel closure is based on a 10-point scale as outlined below:

Description	Points
Panel size has reached 600 Health Net Access members in Health Net systems and 1,800 total members (using AHCCCS's 1800 Report)	10
Panel size is approaching capacity at 600 Health Net Access members	8
A single peer-review and confirmed quality-of-care determination	5
1-2 grievances or complaints regarding availability or wait time	2
3-4 grievances or complaints regarding availability or wait time	4
5-9 grievances or complaints regarding availability or wait time	5
10 or more grievances or complaints regarding availability or wait time	10

When a PCP accrues 10 points in any one quarter, Health Net Access takes the following actions:

- Issues a letter notifying the PCP that his or her panel is closed to future member assignments. A Health Net Provider Network Management (PNM) representative or Health Net Access provider reimbursement specialist visits the PCP to discuss the panel closure, and how the PCP can proactively address the issue and potentially correct this action
- Closes PCP panel to new members until the PCP has dropped below 10 points
- Closes PCP panel to new members for a minimum of an additional two quarters for PCPs who reach 10 points for three consecutive quarters

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PROVIDER SERVICES

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PROVIDER*Update*

CONTRACTUAL | NOVEMBER 21, 2014 | UPDATE 14-577 | 1 PAGE

Health Net Access™

Interest Calculation for Health Net Access Claims

Health Net Access claims that are not paid within the required turnaround times accrue interest. Clean claims paid after 30 calendar days for participating providers, and 45 calendar days of receipt for non-participating providers, are subject to interest payment. The interest period begins on the day after payment is due and ends on the day of payment.

INTEREST RATES

Rates for participating providers are based on the rate published in the Federal Register; the current rate is 2 percent per annum unless a different rate is stated in the *Provider Participation Agreement (PPA)*. Non-participating rates are 10 percent per annum. Interest is not paid on claims for which no payment is due, or claims that are fully denied.

TURNAROUND TIMES

Claims for participating providers must be paid or denied within 30 calendar days. Claims for non-participating providers must be paid or denied within 45 calendar days. Interest is based on the clean claim date if a claim falls outside the claim payment turnaround time. Computation of time does not include the first day (receipt date). Mailing days are not included.

When Health Net receives the requested additional information for professional and institutional unclean claims that were previously denied due to incomplete information, the interest calculation starts from the date Health Net received the additional information to the completion or check date.

CLAIMS PAYMENT STANDARDS

Health Net Access ensures that 95 percent of all clean claims are adjudicated within 30 calendar days of receipt of a clean claim, and 99 percent are adjudicated within 60 calendar days of receipt of the clean claim. (Calendar days include holidays and weekends.)

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

Provider-Relevant Articles Online

Access informative Online News articles today by logging in to provider.healthnet.com. Select the rotating graphic to read or print the articles of interest. Health Net posts new articles each week that cover a variety of topics, such as health plan updates, administrative procedure reminders, quality improvement tips, and health care initiatives.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- Physicians
- Medical Groups/IPAs
- Hospitals
- Ancillary Providers

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NEWS & ANNOUNCEMENTS | NOVEMBER 20, 2014 | UPDATE 14-578 | 1 PAGE

Health Net Access™

Updated 2014 Health Net Access Materials Available Online

Health Net Access materials, updated for 2014, are now available online for participating providers and their staff to access at their convenience. The materials include the following:

- *Health Net Access Provider Reference Guide*
- *Making Practice Perfect – Tools for Working Efficiently with Health Net* provider toolkit

The guide and toolkit are available on the provider website at provider.healthnet.com, under *Working with Health Net > Regulatory > Health Net Access.*

HEALTH NET ACCESS PROVIDER OPERATIONS MANUALS

The Health Net Access provider operations manuals offer participating providers necessary procedural information to ensure Health Net Access members receive appropriate covered services when needed. The manuals were developed specifically for physicians and hospitals serving Health Net Access members. The contents of the manuals are supplemental to the *Provider Participation Agreement (PPA)* and its addendums.

The manuals are located on the Health Net provider website at provider.healthnet.com in the Provider Library. The Provider Library includes operational materials targeted to provider type, including operations manuals, provider updates and letters, contacts, and forms. To access the Provider Library, participating providers must register online at provider.healthnet.com.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

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PROVIDER*Update*

REGULATORY | NOVEMBER 14, 2014 | UPDATE 14-566 | 2 PAGES

Health Net Access™

Health Net Access Fraud, Waste and Abuse Reporting and Training

This update contains important information on the federal False Claims Act (FCA), instructions on how to report suspected fraud, waste and abuse (FWA) and provider training requirements for Health Net Access (AHCCCS).

FEDERAL FALSE CLAIMS ACT

In accordance with the FCA, the following acts are unlawful:

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

The FCA is important because it:

- Outlines the rights of consumers and providers to take action to combat fraud on behalf of the government
- Expands the scope of fraud beyond those who knowingly intend to commit it
- Provides protections to those who bring the false claims to light
- Established stringent penalties for those found guilty

FRAUD, WASTE AND ABUSE

Health care FWA contributes to the rising cost of health insurance, reduces the amount of funds available to pay honest providers, and reduces the available funds used to provide essential medical services for Medicaid patients. Health Net investigates allegations of 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's Code of Business Conduct and Ethics, or accessing personal information or protected health information (PHI) without authorization

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REPORTING FRAUD, WASTE, ABUSE, OR VIOLATIONS OF STANDARDS OF CONDUCT

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

To report suspected FWA, contact Health Net via mail or telephone as listed below:

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

To report potential or actual noncompliance or ethical concerns, contact Health Net via mail or telephone as listed below:

Health Net Access Compliance Officer
Gay Ann Williams
Mail Stop: AZ-900-04-23
1230 West Washington Street, Suite 401
Tempe, AZ 85281
Health Net's Integrity Line: (888) 866-1366

FWA TRAINING

Arizona Health Care Cost Containment System (AHCCCS) has launched the Fraud Awareness for Providers Training through the AHCCCS website at www.azahcccs.gov/multimedia/CBT/healthplanproviderfraud/healthplanproviderfraudfs.htm. Health Net Access participating providers can use this training module to satisfy the AHCCCS training requirement for educating staff and providers on fraud and abuse.

ADDITIONAL INFORMATION

For information on health plan provider fraud and abuse, visit the AHCCCS website at www.azahcccs.gov/fraud/Default.aspx.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

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Health Net Access™

CONTRACTUAL | NOVEMBER 5, 2014 | UPDATE 14-528 | 3 PAGES

Medical Policies – 3rd Quarter 2014

This provider update includes a listing of new and updated Health Net medical policies approved by the Health Net National Medical Advisory Council (MAC) in the third quarter of 2014. For a complete description of new and updated medical policies, visit the Health Net provider website at provider.healthnet.com and select *Working with Health Net > Clinical > Medical Policies*.

PURPOSE OF HEALTH NET MEDICAL POLICIES

Medical policies provide guidelines for determining medical necessity for specific procedures, equipment and services. All services must be medically necessary to be eligible for benefit coverage, unless otherwise defined in the member's benefits contract. The determination for coverage is also based on all of the terms of the individual member's benefits contract, including, but not limited to, eligibility at the time of service and description of covered benefits, limitations and exclusions. In some cases, legal or regulatory mandate requirements may be applicable and may prevail over medical policy. To the extent there are any conflicts between medical policy guidelines and applicable benefit contract language, the benefit contract language prevails. Medical policy is not intended to override the *Member Handbook* or the health insurance policy that defines the member's benefits, nor is it intended to provide medical advice or dictate to providers how to practice. If required, prior authorization must be obtained before services are rendered.

New Policies

Medical Policy	Policy Statement
PROSTATIC URETHRAL LIFT (PUL)	PUL, also known as the transprostatic implant system or the UroLift® System, is proposed as a permanent implant for urinary outflow obstruction in men ages 50 and older with moderate to severe benign prostatic hypertrophy (BPH), refractory to medical treatment. This is considered investigational at this time since there are no long-term studies, which are necessary to determine the safety and efficacy of these implants, as well as the duration of benefits
SACROILIAC JOINT FUSION	Sacroiliac joint fusion procedures, either open or minimally invasive (iFuse), are considered investigational for treating mechanical low back pain due to sacroiliac joint syndrome and sacral insufficiency fractures
ULTRASOUND GUIDANCE FOR PODIATRY INJECTIONS	Considered not medically necessary

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Updated Policies

Medical Policy	Change
BIOFEEDBACK	Added biofeedback training as medically necessary for the treatment of dysfunctional voiding in children, when alternative options have been unsuccessful, such as timed voiding or anticholinergic medications that are frequently helpful to children who do not respond to conservative measures
BIVENTRICULAR PACING/ CARDIAC RESYNCHRONIZATION THERAPY (CRT)	Added CRT as medically necessary with left ventricular ejection fraction (LVEF) of 35 percent or less, sinus rhythm, left bundle-branch block (LBBB) with a QRS duration of 150 ms or greater, and New York Heart Association (NYHA) class II, III or ambulatory IV symptoms
CATHETER ABLATION FOR ATRIAL FIBRILLATION	Changed title of policy to Catheter Ablation for Atrial Fibrillation (previous title: Cryoablation for Atrial Fibrillation). Revised policy to consider catheter ablation for treatment of atrial fibrillation medically necessary when specific criteria are met, based on recommendations from the April 2014 American Heart Association (AHA)/American College of Cardiology (ACC)/Heart Rhythm Society (HRS) Code updates
ELECTRIC TUMOR TREATMENT FIELDS (NOVOTTF™-100A)	Revised policy statement to consider NovoTTF-100A system medically necessary on a case-by-case basis
EXTRACORPOREAL IMMUNOADSORPTION (ECI) USING PROSORBA® COLUMN	Policy retired since Prosorba column is no longer being produced
FIBROSPECT®, FIBROSURE®, ACTITEST®, AND OTHER NON-INVASIVE TESTING FOR LIVER FIBROSIS	Revised policy to consider various noninvasive testing medically necessary, such as FibroSure, FibroSpect, ActiTest, Hepascore®, aspartate aminotransferase (AST) to platelet ratio (APRI), transient elastography (ultrasound based elastography or FibroScan®), and acoustic radiation force impulse (ARFI) for detecting or monitoring hepatic fibrosis in persons with hepatitis C or other chronic liver diseases
GENETIC TESTING INDICATIONS	Added cystic fibrosis, spinal muscular atrophy and fragile X screening as medically necessary with specific criteria, as recommended by American Congress of Obstetricians and Gynecologists (ACOG) Added genetic testing for Charcot-Marie-Tooth disease Type 1A (CMT1A) with peripheral myelin protein 22 (PMP22) and hereditary neuropathy with liability to pressure palsies (HNPP) as not medically necessary
HIV ANTIRETROVIRAL (ARV) DRUG RESISTANCE TESTING	Added to medically necessary section of policy for testing of adults/ adolescents, "HIV drug-resistance studies should be performed before modifying ARV regimens for those entering pregnancy with detectable HIV RNA levels that are above the threshold for resistance testing (greater than 500 to 1,000 copies/mL) while receiving ARV drugs or who have suboptimal viral suppression after starting ARV drugs during pregnancy"
MOLECULAR TUMOR MARKERS FOR NON-SMALL CELL LUNG CANCER (NSCLC)	Added testing for additional genetic alterations using multiplex/next-generation sequencing (NGS) as medically necessary to guide treatment based on recommendations from National Comprehensive Cancer Network® (NCCN)
OBSTRUCTIVE SLEEP APNEA DIAGNOSIS AND MEDICAL TREATMENTS	Added positive airway pressure (PAP) nap sleep study to the not medically necessary section of the policy due to a lack of evidence in the peer-review literature to demonstrate that PAP nap improves patient compliance with C-PAP

Updated Policies, continued

Medical Policy	Change
SELECTIVE INTERNAL RADIATION THERAPY	Title change to Selective Internal Radiation Therapy (TheraSphere®, Sir-Sphere®) and revised section on contraindications with separate criteria for TheraSphere and Sir Sphere. Revised wording in policy statement, but recommendations are unchanged
SHOULDER ARTHROPLASTY	Added to policy statement indications when reverse total shoulder arthroplasty may be considered medically necessary
TRANSCRANIAL MAGNETIC STIMULATION	Criterion #4 was revised to require that the patient has demonstrated resistance to treatment with psychopharmacologic agents as evidenced by a lack of clinically significant response to four trials of such agents, in the current depressive episode, from at least two different agent classes. At least two of the treatment trials must have been administered at an adequate course of mono- or poly-drug therapy with antidepressants involving standard therapeutic doses of at least six-weeks duration
VIDEO ASSISTED THORACOSCOPIC SURGERY (VATS)	Revised policy to consider VATS medically necessary for diagnostic and therapeutic pleural, lung and mediastinal surgery
WIRELESS CAPSULE ENDOSCOPY (WCE)	Added WCE as medically necessary in select cases of celiac disease when criteria are met
WOUND CARE	Added Biobrane® as medically necessary for temporary use in patients with clean non-infected superficial partial-thickness burn wounds. Added GammaGraft®, EZ Derm®, PriMatrix®, Promogran®, Xelma® to the Investigational Wound Care section. Added a reference to the Breast Reconstructive Surgery medical policy

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

PROVIDER*Update*

CONTRACTUAL | OCTOBER 31, 2014 | UPDATE 14-492 | 2 PAGES

Health Net Access™

Fluoride Varnish Application and Pediatric Developmental Screening Certifications for Reimbursement

Effective August 1, 2014, the Arizona Health Care Cost Containment System (AHCCCS) reimburses qualified medical providers for fluoride varnish application and pediatric developmental screenings with proof of certification. Providers must submit proof of training and certification from AHCCCS-approved organizations, listed below, to the Council for Affordable and Quality Healthcare (CAQH) at www.caqh.org. Certification prior to August 1, 2014, is also accepted.

FLUORIDE VARNISH APPLICATION

Certified primary care physicians (PCPs) should apply fluoride varnish starting from the first tooth eruption at age six months to age two. Coverage is limited to services provided in the PCP's office and once every six months, during an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visit for children who are age six months with at least one tooth erupted, with recurrent applications up to age two. For reimbursement, use HCPCS[1] code D1206. After age two, children must visit a dentist for fluoride varnish.

PEDIATRIC DEVELOPMENTAL SCREENING

EPSDT visits must be conducted by certified PCPs and must include a developmental screening for members from birth through age three during the 9-, 18- and 24-month check-ups. PCPs rendering services to EPSDT-eligible members must use AHCCCS-approved developmental screening tools. AHCCCS recommends use of one of the following developmental screening tools:

- Parent's Evaluation of Developmental Screening (PEDS)
- Ages and Stages Questionnaire (ASQ)
- Modified Checklist for Autism in Toddlers (M-CHAT)

PCPs must be trained in the use and scoring of developmental screening tools, and submit certification indicating that they participated in a training sponsored by organizations approved by AHCCCS to CAQH.

For developmental screening service reimbursements, providers should modify the preventive service codes by 25 (to show that standalone services were also provided) and add CPT[2] code 96110.

[1] HCPCS codes were taken from the Centers for Medicare and Medicaid Services (CMS) HCPCS website at www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

[2] CPT codes were taken from the 2014 American Medical Association CPT Code Handbook.

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TRAINING AND CERTIFICATION

Web-based learning opportunities and conferences are available nationwide to provide training on oral health risk assessment and fluoride varnish application. Providers must receive training certification to apply fluoride varnish from one of the following AHCCCS-approved organizations in order to be reimbursed:

- Smiles for Life, a National Oral Health Curriculum
- American Academy of Pediatrics
- American Dental Association
- American Academy of Pediatric Dentistry
- American Academy of Family Physicians
- American Osteopathic Medical Association
- American Association of Pediatric Nurse Practitioners
- American Nurses Association
- American Academy of Physicians Assistants
- Participate in the M-CHAT
- PEDStest.com
- Southwest Autism Research and Resource Center

PCPs must submit certification to CAQH indicating that they participated in fluoride varnish application training from one of these organizations.

ADDITIONAL INFORMATION

If you have questions regarding the information in this update, contact the Health Net Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

Enroll for Electronic Payment and Remittance Options

Enroll for electronic remittance advice (ERA) and electronic funds transfer (EFT) to reduce administrative work and check-processing expenses, and expedite payment and remittance receipt. ERA requires you to also enroll with your clearinghouse. Enrollment forms for ERA and EFT are available online at provider.healthnet.com under *Working with Health Net > EDI > Transfer Funds Electronically*.

PROVIDER*Update*

CONTRACTUAL | OCTOBER 30, 2014 | UPDATE 14-536 | 2 PAGES

Health Net Access™

Dental Services for Health Net Access Members Younger than Age 21

Health Net Access members younger than age 21 are entitled to dental screenings and oral health assessments, as described in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Periodicity Schedule. Primary care physicians (PCPs), physician assistants (PAs) or nurse practitioners (NPs) must perform and document oral health screenings on the appropriate EPSDT tracking form for Health Net Access members.

Oral health screenings are intended to identify gross dental or oral lesions, but are not thorough clinical examinations and do not involve making clinical diagnoses resulting in treatment plans. Depending on the results of the oral health screening, providers must refer members to dentists in accordance with the following time frames:

Category	Time Frame
EMERGENT	Within 24 hours of request
URGENT	Within 3 days of request
ROUTINE	Within 45 days of request

PCPs must refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the Arizona Health Care Cost Containment System (AHCCCS) Dental Periodicity Schedule. Evidence of this referral must be documented on the EPSDT form. Although the AHCCCS EPSDT Dental Periodicity Schedule identifies when routine referrals begin, PCPs may refer EPSDT members for dental assessments earlier than indicated if their oral health screenings reveal potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional.

EPSDT DENTAL SERVICES

EPSDT covers the following dental services:

- Emergency dental services
- Preventive dental services provided as specified in the AHCCCS Dental Periodicity Schedule, including, but not limited to:
  - Diagnostic services, including comprehensive and periodic examinations (two oral examinations and two oral prophylaxis and fluoride treatments per member per year (one every six months) for members ages 12 months through 20 years)
  - Radiology services, including panoramic or full-mouth X-rays, supplemental bitewing X-rays, and occlusal or periapical films, as needed

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- 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. Use of a prophylaxis paste containing fluoride and fluoride mouth rinses do not meet the AHCCCS standard for fluoride treatment (fluoride treatment in the PCP office is not a covered service)
    - For members under age 16, dental sealants on all noncarious permanent first and second molars
    - Space maintainers when posterior primary teeth are lost permanently

AHCCCS DENTAL PERIODICITY SCHEDULE

The AHCCCS Dental Periodicity Schedule lists 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 modifications for children with special health care needs.

Recommendations include three categories of care:

- Clinical oral examination – First examination should begin by age one and be repeated every six months or as indicated by the child's risk status or susceptibility to disease
- Radiographic assessment
- Prophylaxis and topical fluoride

The complete Dental Periodicity Schedule is available in the AHCCCS Medical Policy Manual (AMPM) on the AHCCCS website at www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap400.pdf, Section 431 – Oral Health Care (EPSDT Age Members) (Exhibit 431-1).

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

Enroll for Electronic Payment and Remittance Options

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PROVIDER*Update*

CONTRACTUAL | OCTOBER 23, 2014 | UPDATE 14-518 | 6 PAGES

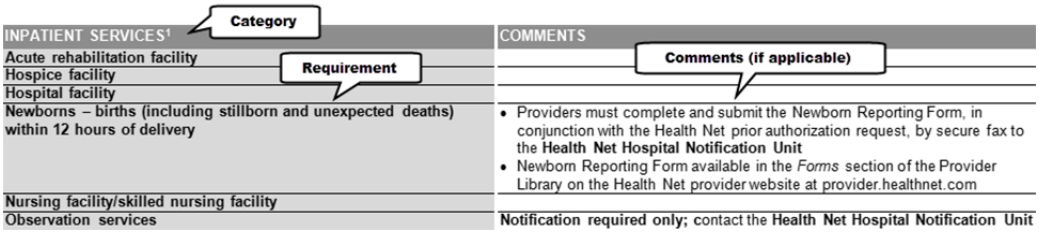
Health Net Access™

Prior Authorization Requirements Changes

Health Net has redesigned the format of its prior authorization requirements, as described below. Additionally, Health Net is implementing changes to the prior authorization requirements for Health Net Access, as outlined on page 2.

FORMAT REDESIGN

Health Net has redesigned the prior authorization requirements to more effectively communicate requirements for Health Net Access providers. The requirements are now formatted as a table. The table is categorized as inpatient services; outpatient procedures, services or equipment; and outpatient pharmaceuticals (submitted under medical benefit claims). Within the table, each requirement is listed by line item along with any comments for the requirement (for example, if an entity other than Health Net authorizes the requirement). Below is a graphic that illustrates the new format.



Following are additional key elements of the redesigned prior authorization requirements:

- The redesigned requirements utilize color and shading within table columns. The requirements, attached for reference, are print-friendly and can be printed clearly in black and white or color
- Requirements that necessitate notification to Health Net rather than prior authorization are noted in bold print within the comments section as "Notification required only"
- Contact information for requesting prior authorization from Health Net or any other entity noted via comments is included in its own table at the end of the requirements, under the heading, Prior Authorization Contacts

ACCESSING PRIOR AUTHORIZATION REQUIREMENTS

Currently effective prior authorization requirements are available on the Health Net provider website at provider.healthnet.com both pre-log in and post-log in, as described below. The redesigned requirements, which include the changes communicated in this update, are attached for reference and replace any previously distributed lists.

Pre-Log In

Requirements are posted under *Working With Health Net > Policies for Non-Contracting Providers > Services Requiring Prior Authorization* (under Additional Resources).

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Post-Log In

Requirements are posted in two places:

- Under *Working With Health Net > Contractual > Services Requiring Prior Authorization*
- In the Health Net Provider Library under *Operations Manuals > Prior Authorization*. Information regarding Health Net's prior authorization policies and procedures is also available in the operations manuals

PRIOR AUTHORIZATION REQUIREMENT CHANGES

The table below indicates an addition to the prior authorization requirements, effective January 1, 2015, and removals or changes, effective immediately.

Requirement	Comments
ADDITIONS – EFFECTIVE JANUARY 1, 2015	
Outpatient pharmaceuticals	Added Entyvio™, Ilaris®, Simponi® Aria™, Soliris®
REMOVALS AND CHANGES – EFFECTIVE IMMEDIATELY	
Dermatology (in-office procedures)	Skin injections and implants (11900-11980) added under comments for clarification; these prior authorization requests are currently reviewed by Health Net
Experimental/investigational services and new technologies	Clarified requirement with "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*"
Maternity	Changed to notification required only
Perinatology referral and care	Changed to notification required only
Outpatient pharmaceuticals (submitted under medical benefit claims)	Removed Boniva®, Novantrone®, Omontys®, Prolia®, Reclast®, Xgeva® Changed Rituxan® (rheumatoid arthritis only) to Rituxan (non-oncology only)

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

Health Net Access™

Arizona

Prior Authorization Requirements

Health Net Access

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. Refer to page 4 for submission information and **prior authorization contacts**.

INPATIENT SERVICES[1]	COMMENTS
Acute rehabilitation facility	
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** • Newborn Reporting Form 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; c**ontact 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**
OUTPATIENT PROCEDURES, SERVICES OR EQUIPMENT	**COMMENTS**
All non-contracting and out-of-state services	
Ambulance	Applies to non-emergency air or ground transportation
Back 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
Cardiac and pulmonary rehabilitation therapy	
Circumcision	Surgical procedure

OUTPATIENT PROCEDURES, SERVICES OR EQUIPMENT, CONTINUED	COMMENTS
Cleft palate reconstructive surgery, including dental and orthodontic services	Surgical procedure
Clinical trials	
Cosmetic services, evaluation and procedure	
Custom orthotics	Applies to members under age 21
Dental	Contact **Dental Benefit Providers**
Dermatology (in-office procedures)	Including: • Chemical exfoliation and electrolysis (17360-17380) • Dermabrasion/chemical peel (15780-15793) • Laser treatment (17106-17108, 17250) • Skin injections and implants (11900-11980)
Dialysis services	**Notification required only**
Genetic testing	Covered only to differentiate between treatment options
Durable medical equipment (DME)	Applies to items exceeding $2,500 in billed charges
Enteral/parenteral 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	Applies to the following services: • Home uterine monitoring • Nursing • Occupational therapy • Physical therapy • Speech therapy • Tocolytic services
Hospice/palliative care	
Hyperbaric oxygen therapy	
Incontinence briefs	Applies to members ages 3 to 20
Intensity modulated radiation therapy (IMRT)	
LifeVest®	
Maternity	• **Notification required only** at the time of first prenatal visit • 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), in conjunction with the Health Net Request for Prior Authorization form • Health Net Request for Prior Authorization form available in the *Forms* section of the Provider Library on the Health Net provider website at provider.healthnet.com
Neuro or spinal cord stimulators	
Neuropsych testing	
Orthognathic procedures (including TMJ treatment)	Surgical procedure

OUTPATIENT PROCEDURES, SERVICES OR EQUIPMENT, CONTINUED	COMMENTS
Outpatient diagnostic procedures	• Contact **MedSolutions** for the following procedures: o Computed tomography (CT) o Magnetic resonance angiography (MRA) scans o Magnetic resonance imaging (MRI) scans o Nuclear cardiac imaging procedures o Positron emission tomography (PET)
Perinatology referral and care	**Notification required only**
Posterior tibial neuro stimulation/pelvic floor stimulation	Surgical procedure
Pregnancy termination	Surgical procedure
Prosthetics	Applies to items exceeding $2,500 in billed charges
Proton beam therapy	
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
OUTPATIENT PHARMACEUTICALS (SUBMITTED UNDER MEDICAL BENEFIT CLAIMS)	**COMMENTS**
Hemophilia factors	Prior authorization required from **HNPS**
Self-injectables	Prior authorization required from **HNPS**
• **Actemra®** • **Aldurazyme®** • **Aralast®** • **Aranesp®** • **Benlysta®** • **Botox®** • **Ceredase®** • **Cerezyme®** • **Cinryze®** • **Dysport®** • **Entyvio™*** • **Fabrazyme®** • **Flolan®** • **Glassia™** • **Ilaris®** • **Intravenous immunoglobulin (IVIG)** • **Krystexxa®** • **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** • ***Entyvio** – prior authorization required, effective January 1, 2015

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 or other departments.

CONTACT INFORMATION	
Prior authorization request	• (888) 926-1736; fax: (855) 764-8513 • Health Net Prior Authorization Request available in the *Forms* section of the Provider Library on the Health Net provider website at provider.healthnet.com
Behavioral health	Coordinated by Magellan Health Services (Regional Behavioral Health Authority (RBHA) in Maricopa County): (800) 564-5465 or www.magellanofaz.com
Dental Benefit Providers	(855) 866-2620 Health Net Dental Dental Benefit Providers AZ Medicaid PO Box 306 Milwaukee, WI 53201
Eligibility and benefits	provider.healthnet.com or (888) 788-4408
Health Net Access Member Services Department	(888) 788-4408; TTD/TTY: (888) 788-4872
Health Net Hospital Notification Unit	(888) 926-1736; fax: (855) 764-8513 After hours and weekends: (888) 926-1736
Medicaid general information – Arizona Health Care Cost Containment System (AHCCCS)	www.azahcccs.gov
Health Net Pharmaceutical Services (HNPS)	(800) 410-6565; fax: (800) 977-4170
MedSolutions for listed outpatient diagnostic procedures	(888) 693-3211; fax: (888) 693-3210

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 (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 services and substance abuse services must be referred to RBHA. If coordination assistance with RBHA is needed, contact the Health Net Access Member Services Department
- 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

PROVIDER*Update*

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Health Net Access™

Claims Processing and Resolution Provider Survey

Arizona Health Care Cost Containment System (AHCCCS) is conducting a survey to ascertain providers' satisfaction with claims processing and resolution by AHCCCS contracting health plans. Providers' feedback is critical to assess and improve current processes.

Providers can complete this brief survey online and indicate their contracting relationship, if any, with each plan listed. To access the survey, visit www.surveymonkey.com/s/AHCCCSProviderSurveyClaims.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- ● Physicians
- ● Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

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www.healthnet.com

NATIONAL PROVIDER COMMUNICATIONS

provider.communications@healthnet.com
fax (800) 937-6086

Enroll for Electronic Payment and Remittance Options

Enroll for electronic remittance advice (ERA) and electronic funds transfer (EFT) to reduce administrative work and check-processing expenses, and expedite payment and remittance receipt. ERA requires you to also enroll with your clearinghouse. Enrollment forms for ERA and EFT are available online at provider.healthnet.com under *Working with Health Net > EDI > Transfer Funds Electronically.*

Health Net Access™

AHCCCS *Provider* Forum

Register today for Health Net's provider training

Health Net Provider Network Management invites you to an upcoming provider forum for Arizona Health Care Cost Containment System (AHCCCS) providers. This no-cost training is designed for Health Net Access primary care physicians (PCPs), obstetricians and gynecologists (OB/GYNs), specialists, and dental providers, as well as their staff, including billing teams.

Date:

Wednesday, November 5, 2014
11:00 a.m. – 2:00 p.m., Mountain time (MT)
Lunch is provided.

Location:

Black Canyon Conference Center
Sonoran Ballroom
9440 North 25th Avenue
Phoenix, AZ 85021

RSVP:

by Friday, October 31, 2014, via fax
Fax: (602) 794-1803
Availability is limited; register soon!

Who should attend?

- PCPs, OB/GYNs, specialists, dental providers, staff, billers
- Two representatives per office

Departments presenting include:

- Behavioral Health Services
- Quality Management/Improvement
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Maternal Child Health (MCH)
- Community Solutions
- Women, Infants and Children (WIC)

If you are unable to attend the training session, materials will be available on the Health Net provider website at provider.healthnet.com under *Working with Health Net > Regulatory > Health Net Access*, or you may request them from the Health Net Quality Improvement Department via email at AHCCCS_Notification@healthnet.com.

Please complete the registration information below and fax it to the number listed above.

Attendee Name (please print)	*Physician/Practice Name & Tax ID*	*Specialty*	*Telephone*

14-498b

PROVIDER*Update*

Health Net Access™

NEWS & ANNOUNCEMENTS | OCTOBER 10, 2014 | UPDATE 14-476sum | 3 PAGES

Summary Update: 2014-2015 Influenza Vaccine Recommendations

On August 15, 2014, the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP) released the Prevention and Control of Influenza with Vaccines Report regarding the use of vaccines to prevent and control influenza for the 2014-2015 season. This update contains influenza vaccine recommendations for the 2014-2015 season. Information in this update is adapted from ACIP's Prevention and Control of Influenza with Vaccines Report.

INFLUENZA RECOMMENDATIONS

Although influenza vaccine strains for 2014-2015 are unchanged from 2013-2014, annual vaccination is recommended for optimal protection against influenza, even for those who received the vaccine in the 2013-2014 season. The following are the vaccine recommendations for 2014-2015:

- Routine influenza vaccination is recommended for all individuals ages six months and older, which is supported by evidence that annual influenza vaccination is a safe and effective preventive health action with potential benefit in all age groups. This recommendation seeks to remove barriers to influenza immunization and signals the importance of preventing influenza across the entire population
- Annual influenza vaccination is a safe and preventive health action that benefits all age groups. However, certain individuals have a higher risk for influenza complications, including individuals ages 65 and older, pregnant women and adults between ages 25 and 64 with certain chronic medical conditions. These people, their household and close contacts, and all health care personnel should continue to be a primary focus for vaccination efforts. In addition, children younger than six months are not eligible for vaccination and remain vulnerable; their parents, siblings and all caregivers should be vaccinated
- Children ages six months through eight years who have never received an influenza vaccine require two doses, administered a minimum of four weeks apart, during their first season of vaccination to optimize immune response
- Children ages six months through eight years who received a total of two or more doses of seasonal vaccine since July 1, 2010, need only one dose of vaccine in 2014-2015. Children who did not receive a total of two or more doses of seasonal vaccine since July 1, 2010, require two doses in 2014-2015
- If a child six months through eight years is known to have received at least two seasonal influenza vaccines during any previous season, and at least one dose of a 2009 H1N1-containing vaccine (that is any season since 2010-2011 seasonal vaccine, or monovalent 2009 (H1N1) vaccine), then the child needs only one dose for 2014-2015. Using this approach, children ages six months through eight years need only one dose of vaccine in 2014-2015 if they have received any of the following (children for whom one of these conditions is not met require two doses in 2014-2015):

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

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- Two or more doses of seasonal influenza vaccine since July 1, 2010
- Two or more doses of seasonal influenza vaccine before July 1, 2010, and one or more doses of monovalent 2009 (H1N1) vaccine
- One or more doses of seasonal influenza vaccine before July 1, 2010, and one or more doses of seasonal influenza vaccine since July 1, 2010

- U.S. influenza vaccines for 2014-2015 contain A/California/7/2009 (H1N1)-like, A/Texas/50/2012 (H3N2)-like, and B/Massachusetts/2/2012-like (Yamagata lineage) virus. Quadrivalent vaccines contain these antigens, including a B/Brisbane/60/2008-like (Victoria lineage) virus
- Fluarix® (GlaxoSmithKline) is an inactivated influenza vaccine (IIV4) for individuals ages three and older
- FluBlok® (Protein Sciences) is a recombinant hemagglutinin influenza vaccine (RIV3) and available for adults ages 18 to 49
- Fluzone® High-Dose (Sanofi Pasteur) is an alternative inactivated vaccine for adults ages 65 and older. Adults ages 65 and older can receive any of the standard-dose trivalent inactivated influenza vaccine (IIV) preparations or Fluzone High-Dose; no preference is indicated
  - Adults under age 65 who receive inactivated influenza vaccine should receive a standard-dose IIV preparation
- Fluzone Quadrivalent (IIV4) (Sanofi Pasteur), in addition to the previous trivalent formulation, is recommended for individuals ages six months and older
- Fluzone Intradermal (Sanofi Pasteur) was licensed in May 2011. This vaccine is an alternative to other IIV4 preparations for individuals ages 18 to 64 with no preferential recommendation
- FluMist (MedImmune), the intranasally administered live attenuated influenza vaccine (LAIV), is indicated for healthy, nonpregnant individuals ages 2 through 49
- LAIV (nasal spray) is the recommended vaccine for healthy children ages 2 to 8 for the 2014-2015 season. Studies indicate that nasal spray may be more effective than a flu shot in younger children. CDC recommends the flu shot as an alternative if the nasal spray is not immediately available so vaccination is not delayed

VACCINES FOR CHILDREN PROGRAM

Influenza vaccination is a benefit for all Health Net Access members over age six months, and is provided by the Vaccines for Children (VFC) program for all eligible members under age 19. VFC has pre-booked the influenza serum from the CDC for the 2014-2015 influenza season and will notify providers when it becomes available. Registered providers may order influenza vaccines monthly through ASIIS/VOMS.

Participating providers must submit claims to Health Net for VFC program-supplied immunizations to receive reimbursement for the administration of the immunization. Administration CPT code and the associated VFC vaccine CPT code are required when requesting payment for the administration fee of VFC vaccines.

For additional information on VFC and the quadrivalent vaccines available for registered providers, refer to the complete update, 14-476, *2014-2015 Influenza Vaccine Recommendations* on the Health Net provider website at provider.healthnet.com > *Updates and Letters > 2014.*

CLAIM SUBMISSION FOR THE NON-VFC INFLUENZA VACCINE

Upon submission of a claim, Health Net reimbursement to providers is in accordance with the terms of the provider's Health Net *Provider Participation Agreement* (*PPA*) and the member's benefit plan design. Refer to the Seasonal Influenza Vaccine Codes table for coding information in the complete update 14-476, *2014-2015 Influenza Vaccine Recommendations* on the Health Net provider website at provider.healthnet.com > *Updates and Letters > 2014.*

ADDITIONAL INFORMATION

Health care providers should begin offering vaccinations as soon as they become available. Since influenza may not appear in certain communities until May, the vaccine should continue to be offered throughout flu season as long as it is available. The complete update 14-476, *2014-2015 Influenza Vaccine Recommendations*, on the Health Net provider website at provider.healthnet.com under *Updates and Letters > 2014* also includes information regarding:

- Detailed ACIP recommendations, which are available online at www.cdc.gov/flu
- Vaccine distribution and ordering instructions, which are available online at www.preventinfluenza.org

- CDC recommendations for use of influenza antiviral medicines (Relenza® (zanamivir) and Tamiflu® (oseltamivir)) for treatment and prevention (chemoprophylaxis) of influenza during the upcoming flu season
- National Influenza Vaccination Week (NIVW) – Beginning December 7, 2014
- Information on different indications as outlined in the Recommended Influenza Vaccines for the United States 2014-2015 Season table

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

PROVIDER*Update*

Health Net Access™

NEWS & ANNOUNCEMENTS | OCTOBER 10, 2014 | UPDATE 14-476 | 7 PAGES

2014-2015 Influenza Vaccine Recommendations

On August 15, 2014, the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP) released the Prevention and Control of Influenza with Vaccines Report regarding the use of vaccines to prevent and control influenza for the 2014-2015 season. This update contains influenza vaccine recommendations for the 2014-2015 season. Information in this update is adapted from ACIP's Prevention and Control of Influenza with Vaccines Report.

Vaccine recommendations apply only to individuals who do not have contraindications to vaccine use. Different influenza vaccine preparations have different indications as licensed by the United States Food and Drug Administration (FDA). Refer to the Recommended Influenza Vaccines for the United States 2014-2015 Season table on page 6 of this update for an overview of these indications. For the most current information regarding influenza vaccine recommendations, visit the CDC website at www.cdc.gov/flu.

Although influenza vaccine strains for 2014-2015 are unchanged from 2013-2014, annual vaccination is recommended for optimal protection against influenza, even for those who received the vaccine in the 2013-2014 season. The following are the vaccine recommendations for 2014-2015:

- Routine influenza vaccination is recommended for all individuals ages six months and older, which is supported by evidence that annual influenza vaccination is a safe and effective preventive health action with potential benefit in all age groups. This recommendation seeks to remove barriers to influenza immunization and signals the importance of preventing influenza across the entire population
- Annual influenza vaccination is a safe and preventive health action that benefits all age groups. However, certain individuals are at a higher risk for influenza complications, including individuals ages 65 and older, pregnant women and adults between ages 25 and 64 with certain chronic medical conditions. These people, their household and close contacts, and all health care personnel should continue to be a primary focus for vaccination efforts. In addition, children younger than six months are not eligible for vaccination and remain vulnerable; their parents, siblings and all caregivers should be vaccinated
- Children ages six months through eight years who have never received an influenza vaccine require two doses, administered a minimum of four weeks apart, during their first season of vaccination to optimize the immune response
- Children ages six months through eight years who received a total of two or more doses of seasonal vaccine since July 1, 2010, need only one dose of vaccine in 2014-2015. Children who did not receive a total of two or more doses of seasonal vaccine since July 1, 2010, require two doses in 2014-2015
- If a child six months through eight years is known to have received at least two seasonal influenza vaccines during any previous season, and at least one dose of a 2009 H1N1-containing vaccine (that is any season since 2010-2011 seasonal vaccine, or monovalent 2009 (H1N1) vaccine), then the child needs only one dose for 2014-2015. Using this approach, children ages six months through eight years need only one dose of vaccine in 2014-2015 if they have received any of the

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fax (800) 937-6086

following (children for whom one of these conditions is not met require two doses in 2014-2015):

  - Two or more doses of seasonal influenza vaccine since July 1, 2010
  - Two or more doses of seasonal influenza vaccine before July 1, 2010, and one or more doses of monovalent 2009 (H1N1) vaccine
  - One or more doses of seasonal influenza vaccine before July 1, 2010, and one or more doses of seasonal influenza vaccine since July 1, 2010

- U.S. influenza vaccines for 2014-2015 contain A/California/7/2009 (H1N1)-like, A/Texas/50/2012 (H3N2)-like, and B/Massachusetts/2/2012-like (Yamagata lineage) virus. Quadrivalent vaccines contain these antigens, including a B/Brisbane/60/2008-like (Victoria lineage) virus
- Fluarix® (GlaxoSmithKline) is an inactivated influenza vaccine (IIV4) for individuals ages three and older
- FluBlok® (Protein Sciences) is a recombinant hemagglutinin influenza vaccine (RIV3) and available for adults ages 18 to 49
- Fluzone® High-Dose (Sanofi Pasteur) is an alternative inactivated vaccine for adults ages 65 and older. Adults ages 65 and older can receive any of the standard-dose trivalent inactivated influenza vaccine (IIV) preparations or Fluzone High-Dose; no preference is indicated
  - Adults under age 65 who receive inactivated influenza vaccine should receive a standard-dose IIV preparation
- Fluzone Quadrivalent (IIV4) (Sanofi Pasteur), in addition to the previous trivalent formulation, is recommended for individuals ages six months and older
- Fluzone Intradermal (Sanofi Pasteur) was licensed in May 2011. This vaccine is an alternative to other IIV4 preparations for individuals ages 18 to 64 with no preferential recommendation
- FluMist (MedImmune), the intranasally administered live attenuated influenza vaccine (LAIV), is indicated for healthy, nonpregnant individuals ages 2 through 49
- LAIV (nasal spray) is the recommended vaccine for healthy children ages 2 to 8 for the 2014-2015 season. Studies indicate that nasal spray may be more effective than a flu shot in younger children. CDC recommends the flu shot as an alternative if the nasal spray is not immediately available so vaccination is not delayed

ADMINISTRATION RECOMMENDATIONS

- IIV preparations with the exception of Fluzone Intradermal should be administered via the intramuscular route. For adults and older children, the deltoid is the preferred site. Infants and younger children should be vaccinated in the anterolateral thigh, whereas the LAIV, FluMist, is intended for intranasal administration only
- Fluzone Intradermal is indicated for individuals ages 18 through 64
- Fluzone High-Dose is indicated for adults ages 65 and older
- LAIV (nasal spray) should be administered to healthy children ages 2 to 8 who have no contraindications, when it is immediately available. If LAIV vaccine is not available, IIV should be administered
- LAIV should not be administered to pregnant women, individuals under age 2 or over 49; adults and children with chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, neurologic/neuromuscular, hematologic, or metabolic disorders; children ages 2 to 4 with asthma or wheezing in the preceding 12 months; adults and children with immunosuppression or their close contacts; and individuals ages six months to 18 years receiving aspirin or other salicylates
- Women who are or plan to be pregnant during influenza season should receive IIV
- Postpartum women can receive LAIV or IIV
- Individuals with a history of egg allergy who report only hives after egg exposure should receive IIV or RIV rather than LAIV. Vaccine recipients should be observed for at least 30 minutes after administration of each vaccine dose for signs of a reaction
- IIV and LAIV are contraindicated in individuals known to have anaphylactic hypersensitivity to eggs or to other components of the influenza vaccine
- All children ages six months through eight years who did not receive at least one dose of the 2013-2014 seasonal influenza vaccine, or for whom it is not certain whether the 2013-2014 seasonal vaccine was received, should receive two doses of the 2014-2015 seasonal influenza vaccine at least four weeks apart

- As a precaution, individuals who are not at high risk for severe influenza complications and who are known to have experienced Guillain-Barré syndrome within six weeks of receipt of an influenza vaccine (IIV or LAIV), generally should not be vaccinated

Health care providers should begin offering vaccinations as soon as they become available. The vaccine should continue to be offered through the flu season as long as it is available, since influenza may not appear in certain communities until May.

Health care administrators should consider the level of vaccination coverage among health care personnel (HCP) to be one measure of a patient safety quality program and implement policies to encourage HCP vaccination (for example, obtain signed statements from HCP who decline influenza vaccination).

Providers may access detailed ACIP recommendations online at www.cdc.gov/flu.

VACCINE DISTRIBUTION AND ORDERING INSTRUCTIONS

The influenza vaccine is being distributed through local vendors and distributors. For the 2014-2015 season, most preparations are available for purchase. Information about distributors who have influenza vaccine is available online at www.preventinfluenza.org.

VACCINES FOR CHILDREN PROGRAM

Influenza vaccination is a benefit for all Health Net Access members over age six months, and is provided by the Vaccines for Children (VFC) program for all eligible members under age 19.

VFC has pre-booked the influenza serum from the CDC for the 2014-2015 influenza season and will notify providers when it becomes available. All influenza vaccines for the 2014-2015 flu season are quadrivalent. The influenza vaccine may not be available for the VFC program at the same time as private influenza doses.

Registered providers may order influenza vaccines monthly through ASIIS/VOMS. The VFC program will have the following seven quadrivalent vaccines available to order for eligible members:

- Fluarix (GSK) – 0.5 ml syringes for individuals ages 3 through 18 (NDC #58160-0901-52)
- FluLaval (GSK) – 5.0 ml multi-dose vial for individuals ages 3 through 18 (NDC #19515-0891-11)
- Flumist (MedImmune) – Intranasal sprayers for individuals ages 2 through 18 (NDC #66019-0301-01)
- Fluzone (Sanofi) – 0.25 ml syringes for children ages 6 months through 35 months (NDC #49281-0514-25)
- Fluzone (Sanofi) – 0.5 ml single dose vials for individuals ages 3 through 18 (NDC #49281-0414-10)
- Fluzone (Sanofi) – 0.5 ml syringes for individuals ages 3 through 18 (NDC #49281-0414-50)
- Fluzone (Sanofi) – 5.0 ml multi-dose vials for individuals ages 6 months through 18 (NDC #49281-0621-15)

Participating providers must submit claims to Health Net for VFC program-supplied immunizations to receive reimbursement for the administration of the immunization. Administration CPT code and the associated VFC vaccine CPT code are required when requesting payment for the administration fee of VFC vaccines.

Providers who need additional doses of the influenza vaccine or more information on the VFC program may contact VFC at (602) 364-3642.

CLAIM SUBMISSION FOR THE NON-VFC INFLUENZA VACCINE

Upon submission of a claim, Health Net reimbursement to providers is in accordance with the terms of the provider's Health Net *Provider Participation Agreement* (*PPA*) and the member's benefit plan design. Refer to the Seasonal Influenza Vaccine Codes table on page 5 for coding information.

RELENZA® AND TAMIFLU® TREATMENT FOR INFLUENZA

While the flu vaccine is the best protection against influenza viruses, CDC also provides recommendations for use of influenza antiviral medicines (Relenza® (zanamivir) and Tamiflu® (oseltamivir)) for treatment and prevention (chemoprophylaxis) of influenza during the upcoming flu season. For 2014-2015, priority use of antiviral medications continues to be for individuals hospitalized with influenza and those at increased risk of influenza-related complications. Most healthy individuals with the flu do not need to be treated with antiviral medications.

Priority for the use of oral antiviral medications in the 2014-2015 season are:

- Individuals with suspected or confirmed influenza requiring hospitalization

- Individuals with suspected or confirmed influenza who are at higher risk for complications, including:
  - Children younger than age 2
  - Individuals ages 65 and older
  - Individuals with certain chronic medical conditions (such as asthma, heart failure or chronic lung disease) and those with a weak immune system (due to illnesses such as diabetes and HIV)
  - Individuals younger than age 19 who are receiving long-term aspirin therapy

Children ages 2 to 4 are more likely to require hospitalization or urgent medical evaluation for influenza compared with older children, although the risk is much lower for 2- to 4-year-olds than for children younger than age 2. Children ages 2 through 4 without high-risk conditions and with mild illness do not necessarily require antiviral treatment.

Coverage for zanamivir and oseltamivir is subject to Health Net's benefit plan terms and conditions. Refer to the CDC website at www.cdc.gov/flu/antivirals/index.htm for up-to-date information on the recommendations for the use of influenza antiviral medications.

NATIONAL INFLUENZA VACCINATION WEEK

The week of December 7, 2014, is nationally observed as National Influenza Vaccination Week (NIVW). NIVW was established to highlight the importance of continuing influenza vaccination, as well as fostering greater use of flu vaccine after the holiday season into January and beyond.

CDC is supporting organizations and providers across the country in their vaccination efforts during NIVW. Visit the CDC website at www.cdc.gov/flu/NIVW/resources.htm for print materials, Web tools (banners, buttons and badges that can be added to a website), audio/video tools, and public service announcements that promote vaccination.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

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SEASONAL INFLUENZA VACCINE CODES[1]

CPT/HCPCS Code	Code Description
	ADMINISTRATION CODES
90460	Immunization administration through age 18 via any route of administration, includes counseling of the patient/family; first injection (single or combination vaccine/toxoid)
90461	Each additional immunization administration (list separately in addition to code for primary procedure)
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)
90473	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)
G0008 (Medicare Advantage only)	Administration of influenza virus vaccine
	VACCINE CODES
90655	Influenza virus vaccine, trivalent, split virus, preservative-free, when administered to children ages 6-35 months, for intramuscular use
90656	Influenza virus vaccine, trivalent, split virus, preservative-free, for use when administered to individuals ages 3 and older, for intramuscular use
90657	Influenza virus vaccine, trivalent, split virus, when administered to children ages 6-35 months, for intramuscular use
90658	Influenza virus vaccine, trivalent, split virus, when administered to children ages 3 and older, for intramuscular use
90660	Influenza virus vaccine, trivalent, live, for intranasal use, for individuals ages 2 and older
90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative- and antibiotic-free, for intramuscular use
90662	Influenza virus vaccine, preservative-free, enhanced immunogenicity via increased antigen content
90664	Influenza virus vaccine, pandemic formulation, live, for intranasal use (vaccine pending FDA approval)
90666	Influenza virus vaccine, pandemic formulation, split virus, preservative-free, for intramuscular use (vaccine pending FDA approval)
90667	Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use (vaccine pending FDA approval)
90668	Influenza virus vaccine, pandemic formulation, split virus, for intramuscular route (vaccine pending FDA approval)
90672	Influenza virus vaccine, quadrivalent, live, for intranasal use (code price is per dose – 0.2 mL)
90685	Influenza virus vaccine, quadrivalent, split virus, preservative-free, when administered to children 6-35 months of age, for intramuscular use (code price is per 0.25 mL)
90686	Influenza virus vaccine, quadrivalent, split virus, preservative-free, when administered to individuals 3 years of age and older, for intramuscular use (code price is per 0.5 mL)

[1] CPT code descriptions were taken from the 2013 AMA CPT Code Handbook. HCPCS code descriptions were taken from the Centers for Medicare and Medicaid Services (CMS) HCPCS Code Sets.

RECOMMENDED INFLUENZA VACCINES FOR THE UNITED STATES 2014-2015 SEASON[2]

VACCINE	TRADE NAME	MANUFACTURER	PRESENTATION	MERCURY CONTENT (MCG HG/0.5 ML DOSE)	AGE GROUP	NO. OF DOSES	ROUTE
IIV3	Afluria®	CSL Limited	0.5 ml prefilled syringe	0	≥ 9 years[3]	1	IM[4]
			5.0 ml multidose vial	24.5	≥ 9 years	1	IM[4]
IIV3	Fluarix®	GlaxoSmithKline	0.5 ml prefilled syringe	0	≥ 3 years	1	IM[4]
IIV3 (cell culture-based)	Flucelvax®[5]	Novartis Vaccines	0.5 ml prefilled syringe	0	≥ 18 years	1	IM[4]
IIV3	FluLaval®	ID Biomedical Corp. of Quebec, a subsidiary of GlaxoSmithKine	5.0 ml multidose vial	<25	≥ 3 years	1	IM[4]
IIV3	Fluvirin®	Novartis Vaccine	0.5 ml prefilled syringe	<1.0	≥ 4 years	1	IM[4]
			5.0 ml multidose vial	25	≥ 4 years	1 or 2	IM[4]
IIV3	Fluzone®	Sanofi Pasteur					
			0.5 ml prefilled syringe	0	≥ 36 months	1 or 2[6]	IM[4]
			5.0 ml multidose vial	25	≥ 6 months	1 or 2[6]	IM[4]
IIV3	Fluzone Intradermal[7]	Sanofi Pasteur	0.1 ml prefilled microinjection system	0	18 to 64 years	1[6]	ID[8]
IIV3 high dose[9]	Fluzone High-Dose	Sanofi Pasteur	0.5 ml prefilled syringe	0	≥ 65 years	1[6]	IM[4]
IIV4	Fluarix Quadrivalent	GlaxoSmithKline	0.5 ml prefilled syringe	0	≥ 3 years	1	IM[4]
IIV4	FluLaval Quadrivalent	ID Biomedical Corp. of Quebec, a subsidiary of GlaxoSmithKine	0.5 ml prefilled syringe	0	≥ 3 years	1 or 2	IM[4]
			5.0 ml multidose vial	<25	≥ 3 years	1 or 2	IM[4]
IIV4	Fluzone Quadrivalent	Sanofi Pasteur	0.25 ml prefilled syringe	0	6 to 35 months	1[7]	IM[4]
			0.5 ml prefilled syringe	0	≥ 36 months	1[7]	IM[4]
			0.5 ml vial	25	≥ 36 months	1[7]	IM[4]
RIV3	FluBlok®	Protein Sciences	0.5 ml vial	0	18 to 49 years	1	IM[4]
LAIV4	FluMist® Quadrivalent[10]	MedImmune	0.2 ml prefilled intranasal sprayer	0	2 to 49 years	1 or 2[11]	IN

Abbreviations: IIV = inactivated influenza vaccine; LAIV = live-attenuated influenza vaccine; IM = intramuscular; ID = intradermal; IN = intranasal; RIV = recombinant hemagglutinin influenza vaccine.

[2] Adapted from Recommended Influenza Vaccines for the U.S. 2014-2015 season table on the CDC website at www.cdc.gov/flu/about/qa/vaxsupply.htm.

[3] Age indication per package insert is for individuals ages 5 and older; however, the ACIP recommends Afluria not be used in children ages 6 months through 8 years because of increased risk of febrile reactions noted in this age group with CSL's 2010 Southern Hemisphere IIV3. If no other age-appropriate, licensed inactivated seasonal influenza vaccine is available for a child age 5 to 8 who has a medical condition that increases the child's risk for influenza complications, Afluria can be used; however, providers should discuss with the parents or caregivers the benefits and risks of influenza vaccination with Afluria before administering this vaccine. Afluria may be used in individuals ages 9 and older.

[4] For adults and older children, the recommended site of vaccination is the deltoid muscle. The preferred site for infants and young children is the anterolateral aspect of the thigh. Specific guidance regarding site and needle length for intramuscular administration may be found in the ACIP General Recommendations on Immunization.

[5] Information not included in package insert. The total egg protein is estimated to be less than 50 femtograms (5 x 10-8 grams) total egg protein, of which a fraction is ovalbumin, per 0.5 mL dose of Flucelvax.

[6] Available upon request from upon request from Sanofi Pasteur, by telephone at (800) 822-2463, or email at MIS.Emails@sanofipasteur.com.

[7] Inactivated influenza vaccine, intradermal: A 0.1-mL dose contains 9 µg of each vaccine antigen (27 µg total).

[8] The preferred site is over the deltoid muscle. Fluzone Intradermal is administered using the delivery system included with the vaccine.

[9] Inactivated influenza vaccine, high-dose: A 0.5-mL dose contains 60 µg of each vaccine antigen (180 µg total).

[10] It is anticipated that the quadrivalent formulation of FluMist will replace the trivalent formulation for the 2014-15 season. FluMist is shipped refrigerated and stored in the refrigerator at 35°F–46°F (2°C–8°C) after arrival in the vaccination clinic. The dose is 0.2 mL divided equally between each nostril. Health-care providers should consult the medical record, when available, to identify children ages 2 to 4 with asthma or recurrent wheezing that might indicate asthma. In addition, to identify children who might be at greater risk for asthma and possibly at increased risk for wheezing after receiving LAIV, parents or caregivers of children ages 2 to 4 should be asked: "In the past 12 months, has a health-care provider ever told you that your child had wheezing or asthma?" Children whose parents or caregivers answer "yes" to this question and children who have asthma or who had a wheezing episode noted in the medical record within the past 12 months should not receive FluMist.

[11] Flumist is indicated for healthy, non-pregnant individuals ages 2 to 49. Individuals who care for severely immunosuppressed individuals who require a protective environment should not receive FluMist given the theoretical risk of transmission of the live attenuated vaccine virus.

PROVIDER*Update*

CONTRACTUAL | OCTOBER 2, 2014 | UPDATE 14-468 | 1 PAGE

Health Net Access™

Behavioral Health Referral Process for Health Net Access

Health Net Access primary care physicians (PCPs) may provide outpatient behavioral health services for anxiety, depression, postpartum depression, and attention deficit hyperactivity disorder (ADHD), within the scope of their practice. PCPs coordinate referrals for members requiring specialty or inpatient behavioral health services through the Tribal/Regional Behavioral Health Authority (T/RBHA) system. The T/RBHA for Health Net Access members is Mercy Maricopa Integrated Care (MMIC). This update provides the behavioral health referral process PCPs must follow.

OBTAINING THE REFERRAL FORM

PCPs must refer members for specialty or inpatient behavioral health services via the behavioral health referral form (PM Form 103.1). PCPs may obtain the form via email, fax or online as follows:

- Email request to AZBHRBHA@healthnet.com
- Fax request to (855) 653-7076
- Download from the Health Net provider website at provider.healthnet.com > *Working with Health Net > Quality > AZ Medicaid – Behavioral Health for PCPs > Additional Resources*

COMPLETING THE FORM

The PCP must complete page one of the referral form; there is no need to include medical records. Then, the PCP must submit the completed referral form via secure fax to the MMIC dedicated behavioral health referral line at (844) 424-3975. MMIC completes page two and returns the form to the PCP upon completion of the referral process.

GENERAL PSYCHIATRIC CONSULTATIONS

Health Net PCPs with general diagnostic and treatment questions may contact T/RBHA behavioral medical practitioners by telephone at (800) 564-5465.

ONE-TIME FACE-TO-FACE EVALUATIONS

A PCP may request that a member has a one-time, face-to-face psychiatric evaluation with the T/RBHA behavioral health provider for treatment, ongoing behavioral health care or medication management provided by the PCP. The PCP must complete the behavioral health referral form (PM Form 103.1) and submit it to the T/RBHA via secure fax at (844) 424-3975, or request the member's face-to-face psychiatric consultation by telephone at (800) 564-5465.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408 or the behavioral health coordinator by email at AZBHRBHA@healthnet.com.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- ● Physicians
- ○ Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

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CONTRACTUAL | SEPTEMBER 30, 2014 | UPDATE 14-444 | 1 PAGE

Health Net Access™

Nutritional Assessment and Nutritional Therapy Reminder

Health Net Access covers nutritional therapy for Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible Health Net Access members. Nutritional therapy is covered for enteral, parenteral or oral use when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake.

Primary care physicians (PCPs) must assess members at each visit and send a referral to Health Net Access for members who require nutritional therapy. To initiate a referral for a nutritional assessment, complete the Health Net Access referral form and fax to the Health Net Prior Authorization Department at (855) 764-8513. Prior authorization is not required when the nutritional assessment is ordered by the member's PCP.

PRIOR AUTHORIZATION FOR NUTRITIONAL THERAPY

Prior authorization is always required for nutritional therapy. Once Health Net Access approves the prior authorization, providers should complete the Commercial Oral Nutritional Supplements form in its entirety and fax it directly to the Health Net Prior Authorization Department at (855) 764-8513 for handling. The Commercial Oral Nutritional Supplements form is available on the Health Net provider website at provider.healthnet.com in the Provider Library under *Forms*.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

Discover Helpful Tools to Support Your Office

The Provider Library online at provider.healthnet.com allows participating providers to quickly access pertinent information to assist in their everyday interaction with Health Net. The Provider Library includes operations manuals, communications (updates and letters), Online News articles, forms, Health Net contact information, and more.

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CONTRACTUAL | SEPTEMBER 23, 2014 | UPDATE 14-403 | 1 PAGE

Health Net Access™

Obstetrical Services Billing Reminder

Arizona Health Care Cost Containment System (AHCCCS) requires all health plans to report all prenatal care visits by individual billing date. This does not impact policies related to global billing; however, it does require that all prenatal care dates of service (DOS) be reported on claims. Prenatal care visits should be scheduled in accordance with American Congress of Obstetricians and Gynecologists (ACOG) standards. Billing codes should include all codes at delivery for delivery type, gestational age and weight of newborn.

SUBMITTING CLAIMS

In compliance with this requirement, Health Net Access requires obstetrical (OB) providers who render care to Health Net Access members to submit claims on the CMS-1500 form for each individual prenatal care visit, or provide a global claim with individual DOS for each prenatal care visit. Each prenatal date of service must be billed individually.

For global OB claims, appropriate delivery CPT procedure codes are billed in addition to prenatal visits. Postpartum visits are billed with the appropriate evaluation and management (E&M) CPT codes (99211-99215) on individual service lines with 1 in the units field for each DOS. Below are examples of a global OB and individual claim.

Global OB Claim[1]	Non-Global OB Individual Claim
OB PROVIDING 10 PRENATAL VISITS AND DELIVERY	**OB PROVIDING 3 PRENATAL VISITS**
Line 1: OB total care and delivery CPT code	Line 1: Appropriate delivery only CPT code
Lines 2-9: Prenatal visit code with DOS and E&M CPT code	Line 2: First prenatal visit billed with DOS and E&M CPT code
Line 10: Postpartum visit billed with DOS and E&M CPT code	Line 3: Second prenatal visit billed with DOS and E&M CPT code
	Line 4: Third prenatal visit billed with DOS and E&M CPT code
	Line 5: Postpartum visit billed with the DOS and E&M CPT code

[1]All series included in the global OB package are billed with the delivery. Reimbursement is made on the total OB care delivery CPT code.

Health Net Access reimburses obstetrical care as a global OB package, including all prenatal visits, delivery, postpartum visits, and all services associated with admission to and discharge from hospital. Providers must document all prenatal care visits by submitting OB claims to Health Net Access in a timely manner. Reimbursement is not provided with submission of each OB claim. This requirement is in addition to the global OB claim submission for which payment is made.

For questions on OB claims submission, contact Health Net's Maternal Child Health/Early and Periodic Screening, Diagnosis and Treatment (MCH/EPSDT) manager at (602) 794-1880.

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PROVIDER*Update*

NEWS & ANNOUNCEMENTS | SEPTEMBER 15, 2014 | UPDATE 14-386sum | 2 PAGES

Health Net Access™

Summary Update: Quality Management Program

This communication provides a summary of the components of the Health Net Access, Inc. (Health Net) multifaceted quality management (QM) program, including its quality and process improvement (QI/PI) activities and instructions on how to obtain additional information about the program. Providers are encouraged to review the complete description of the Health Net QI program at least annually to be familiar with the programs and resources available to assist in improving members' health.

OVERVIEW

The Health Net 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 and systematic basis. The QM program also supports the identification and pursuit of opportunities to improve health outcomes and satisfaction. The program includes the development and implementation of standards for clinical care and service, the measurement of adherence to the standards, and the implementation of actions to improve performance. Standards include, but are not limited to:

- Clinical practice guidelines
- Medical management/utilization management
- Maternal child health (MCH)/Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Complex case management
- Preventive health guidelines
- Pharmaceutical management
- Provider accessibility standards
- Member rights and responsibilities
- Medical record documentation

More extensive information on all the programs listed in this summary update is available on the Health Net provider website at provider.healthnet.com. Additional information located online includes:

- Member appeals
- Utilization management process, authorization of care and criteria
- Use of protected health information (PHI)

ADDITIONAL INFORMATION

A complete overview of the components of the quality management program is available in provider update 14-386*, Quality Management Program*, available in the Provider Library on the Health Net provider website at provider.healthnet.com under *Updates and Letters > 2014.* Providers who do not have access to the Internet may request a print

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copy of update 14-386 by contacting the Health Net National Provider Communications Department by fax at (800) 937-6086, or by email at provider.communications@healthnet.com. More extensive program descriptions are also contained within the Health Net provider operations manuals online in the Provider Library.

Providers can visit the QI Corner on the Health Net provider website at provider.healthnet.com under *Working with Health Net > Quality > Quality Improvement Corner* to view Health Net's quality outcomes and progress towards goals. The QI Corner also contains tools and materials that can assist providers in delivering care that upholds the standard and performance that members expect.

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

Discover Helpful Tools to Support Your Office

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Health Net Access™

NEWS & ANNOUNCEMENTS | SEPTEMBER 15, 2014 | UPDATE 14-386 | 12 PAGES

Quality Management Program

This communication provides an overview of the components of the Health Net Access, Inc. (Health Net) multifaceted quality management (QM) program, including its quality and process improvement (QI/PI) activities and instructions on how to obtain additional information about the program. Health Net develops an annual QM program work plan addressing all requirements of the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency. Providers are encouraged to review the complete description of the QM program at least annually to be familiar with the programs and resources available to assist in improving members' health. For the most current and accurate information, Health Net recommends that providers regularly visit the Health Net provider website at provider.healthnet.com. A complete copy of Health Net's QM program description and overall progress toward meeting QM goals is available upon request from the Health Net QM Department.

OVERVIEW

The Health Net 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 and systematic basis. The QM program also supports the identification and pursuit of opportunities to improve health outcomes and satisfaction. The program includes the development and implementation of standards for clinical care and service, the measurement of adherence to the standards and the implementation of actions to improve performance. Standards include, but are not limited to:

- Clinical practice guidelines
- Medical management/utilization management
- Maternal child health (MCH)/Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Complex case management
- Preventive health guidelines
- Pharmaceutical management
- Provider accessibility standards
- Member rights and responsibilities
- Medical record documentation

OPEN CLINICAL DIALOGUE

Health Net practitioners and providers are encouraged to communicate freely with members regarding their medical conditions and treatment alternatives, including medication treatment options, regardless of coverage limitations. In addition, Health Net strongly recommends communication between primary care physicians (PCPs) and behavioral health specialists to ensure members' safety and continuity of care.

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WHOLE-PERSON STRATEGY

Through Decision Power®[1], Health Net unifies programs, from wellness to complex care, reflecting Health Net's commitment to a whole-person strategy. Members may access wellness programs related to obesity prevention, smoking cessation, pregnancy support, and disease management for heart failure (HF), chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), asthma, and diabetes by logging in to the Health Net member website at www.healthnet.com.

Decision Power Program

Health Net's Decision Power program provides a fully integrated, health management solution aimed to improve the health and quality of life for Health Net members. Through personalized interventions and contemporary behavior change methodologies, Health Net's experienced clinical staff can assist members at risk and diagnosed with chronic health conditions to better manage their conditions through education, empowerment and support. Decision Power includes end-to-end clinical management that encompasses health and wellness, disease management, case management, and women and children's health.

The Decision Power electronic data platform provides users with flexible technology that integrates all data regarding a member's wellness, chronic disease and maternity. It also integrates data from point-of-care devices into clinical workflows creating a complete view of a member's current and past health. The integrated care system provides a complete member profile allowing timely and actionable identification of gaps in care, and the opportunity to effectively reduce delays in care that often result in poor health outcomes. Additionally, registered medical groups also have access to the integrated care system through the Provider Activity Dashboard (PAD). Using PAD, providers can view their patient's Health Risk Questionnaire (HRQ) results, case management or disease management status, and any alerts related to medication adherence and usage or gaps in care. Member information and reports are offered in a secure environment to allow for more continuous and coordinated care. Decision Power collaborates with participating physicians for the best possible health outcomes for Health Net members. Providers may request PAD access or training via email to Maria Nuno at maria.f.nuno@healthnet.com.

Decision Power Wellness Programs

Health Net offers many tools and programs to help members adopt and maintain healthy lifestyles, such as:

- Health risk questionnaire (HRQ) – An online interactive tool that helps members identify health risks based on current lifestyle behaviors and family history. Members are provided a summary of their HRQ results that can be printed and shared with their physicians
- Personal health record – An online secure database where members can track important medical history, including health conditions, immunizations, medications, tests, and procedures. Information from the HRQ automatically becomes part of their personal health record and claim
- Healthy Living programs – Comprehensive behavior change programs that provide information and tools to improve health and reduce disease risk. The duration of the programs are six weeks and include achievable goals personalized to individual preferences and interests. Each program focuses on one health topic and includes a to-do list of action items to help individuals reach their goals. Healthy Living program topics include stress management, weight loss, nutrition, healthy aging, and more
- Decision Power healthy discounts – Exclusive discounts on weight loss programs, vitamins, herbs and supplements, health clubs, and other health-related products and services, including discounts with Jenny Craig® and Weight Watchers®
- Tools to monitor prescription history and check medication interactions; estimate cost of care for more than 100 conditions, 50 procedures or surgeries, and 200 medical tests or visits; compare hospital performance on more than 160 common diagnoses and procedures; and help members understand their health plan options, so that they can choose the plans that best fit their families

DISEASE MANAGEMENT

The Decision Power disease management program provides support to members with chronic conditions, including HF, COPD, CAD, diabetes, and asthma. Decision Power disease management helps increase the efficiency and effectiveness of care, leads to more timely action by members, and helps develop more personalized and actionable solutions that ultimately lead to improved health outcomes. Health Net provides participants and their providers the programs, tools, connectivity, and information to make better health care decisions to:

- Slow the progression of the disease and the development of complications through proven program interventions
- Change behaviors and improve lifestyle choices by using demonstrated behavior change methodologies

- Improve compliance with guidelines and 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 (ER) visits, hospitalization and medication errors, and prevent future occurrences

COMPLEX CASE MANAGEMENT

Health Net's complex case management program targets the most complex cases, often with life-limiting diagnoses, and assists members who have critical barriers to their care. Trained nurse case managers provide intensive, face-to-face contact with Health Net members, their families and caregivers. These members often have multiple comorbid conditions and need assistance in planning, managing and executing their care.

Health Net contracts with Alere™ to manage the complex case management programs. Alere provides services that supplement our case management programs, including intensive, face-to-face contact, as needed, between care managers and Health Net members who have multiple comorbid conditions. This individualized approach helps support members' complex treatment plans and targets the most medically complex cases. Once a Health Net member is selected to participate in the program, a care manager from Alere contacts the member's physician and works closely with that physician to coordinate care for the member.

Referral Guidelines

Alere conducts daily utilization surveillance to identify appropriate members for this program; however, providers may also become aware of a severely ill Health Net member not currently enrolled in this program who may benefit from complex case management services. Providers should use the criteria below when considering whether to refer a member to the Alere complex case management program.

The program's target population is comprised of patients with one or more of the following:

- Significantly poor diagnoses, such as advanced cancer and end-stage disease, including HF, COPD and multiple sclerosis
- Significant symptoms, such as disease-related pain, dyspnea, fatigue, nausea, constipation, and depression
- Multiple care providers that may not be communicating with each other, which increases the risk of an acute event, such as hospital readmission
- Complex psychosocial issues, including:
  - Inadequate support system and caregiver burnout
  - Unsafe environment
  - Significant financial issues

Providers should consider the below questions to determine whether the member has one or more of the following issues that cannot be managed by the provider's office or treating specialists:

- Does the member have a terminal diagnosis or prognosis and struggle with whether to proceed with aggressive or palliative treatment?
- Is the member experiencing significant problems due to disease-related pain and symptom control, such as fatigue, anxiety, nausea, constipation, dyspnea, or depression?
- Does the member live in an unsafe environment?
- Does the member have significant financial issues?
- Does the member have multiple providers of care that may not be communicating, which creates an ongoing risk for an acute event, such as readmission?
- Has the member developed severe, complicated comorbidities?
- Does the member have an inadequate support system or is the primary caregiver suffering from burnout?

If a Health Net member meets any of these criteria, providers may contact the Health Net Case Management Department at (888) 732-2730. Members who want to self-refer to this program may call the toll-free Member Services number on the back of their Health Net identification (ID) cards. The Member Services representative contacts the Case Management

Department with the member's information for appropriate outreach. Contacting the Case Management Department does not automatically qualify the member for the Alere complex case management program.

CareAlerts for Members and Providers

The Decision Power CareAlerts program applies predictive modeling algorithms to identify clinical gaps in care, medication interactions and dangerous medication side-effects across the member population. Results identify actionable opportunities to improve quality of care and address medication safety for specific individuals.

The CareAlerts program promotes physician-patient relationships and encourages Health Net members to share the information included in the CareAlerts with their providers to discuss how to better manage members' health. The goal is to improve member treatment plan compliance and care coordination for clinical and quality outcomes.

The data-driven CareAlerts program includes pharmacy, medical, laboratory, and other claims data, and identifies several patient-specific care gaps within the following four categories. These care gap categories were developed based on national guidelines, Healthcare Effectiveness Data and Information Set (HEDIS®2) measures, and evidence-based health management and prevention recommendations:

- Prevention – screening tests, immunizations and follow-up visits
- Care gaps – suboptimal therapies for chronic conditions, such as appropriate pharmacological therapies or biometric monitoring goals
- Medication therapy – age-appropriate therapy; some medications have a higher risk for the elderly
- Prescription adherence and safety – medication and disease interactions, medication adherence or early discontinuation of maintenance medications, or duplicate therapies

Technology and content management, along with a suite of proprietary business rules, determine the following for each patient-specific care gap result:

- Message recipient
- Communication mode
- Message content
- Optimal timing for communication using message prioritization rules
- Message frequency

Healthy Pregnancy Program

Health Net's Healthy Pregnancy program is available to Health Net Access members and provides a range of resources during pregnancy. The program provides resources to educate women and screen for high-risk pregnancies. Additionally, the program underscores the importance of perinatal care and the patient-provider relationship while providing patients with access to additional support and educational resources. The program includes the following elements:

- Access to BabyLine® – Members enrolled in the Healthy Pregnancy program will have access to Health Net's pregnancy telephone line up to six weeks following the birth of their babies. The line is staffed with experienced perinatal nurses who are available 24 hours a day, seven days a week
- Obstetric (OB) risk assessment and education – Components of this program include initial assessment to identify members with high-risk obstetrical conditions; follow-up assessment completed at approximately 28 weeks; and outcomes assessment conducted post-delivery. In addition to risk screening and assessments, members enrolled in the Health Pregnancy program also receive educational materials on pregnancy-related issues and access to online tools and resources
- OB case management – This program offers the experience of high-risk OB nurse case managers who are available 24 hours a day, seven days a week. OB case management has been shown to prolong pregnancies, improve birth weights and minimize hospitalizations. A high-risk OB nurse case manager is assigned to each member with high-risk obstetrical conditions to create a unique care plan with goals, support, target dates, and periodic assessments, and maintains regular contact with the member through Health Net's high-risk nurse outreach component

Neonatal Intensive Care Unit

Health Net contracts with Alere to manage the Health Net neonatal intensive care unit (NICU) care management program to improve outcomes for infants admitted to the NICU or other specialty care unit, providing on-site case and utilization management. Other program highlights include:

- Weekly reviews and follow-up 14 days after discharge
- Family involvement and education
- Discharge planning
- Reduced lengths of stay and readmissions

Nurse24℠

Nurse24℠ (N24) is a telephonic support program that empowers members to better manage their health. N24 offers support for members coping with chronic and acute illness, episodic or injury-related events and other health care issues. Highly trained registered nurses are available 24 hours a day, seven days a week to monitor and process health care inquiries that help members make informed health care decisions.

N24 staff are trained in telephone triage, and the health information manager may help members navigate through questions and concerns about symptoms, appropriate treatment choices, comorbid conditions, and additional risk factors. Utilizing an accredited knowledge base of more than 5,500 health topics, the nurses have additional tools to help triage calls effectively and appropriately. The N24 team also refers members to Decision Power programs that include, but are not limited to, disease management, maternity and telephonic case management programs.

N24 program highlights include:

- Chat capability from the member portal with N24 clinicians
- Health information managers with experience in discovering health problems and who are trained in telephone triage
- Improved continuity of care through integration with Decision Power disease management services
- Help to reduce excessive or unnecessary ER visits
- Access to nationally recognized Healthwise® Knowledgebase that offers information on more than 5,500 health topics

AMBULATORY CASE MANAGEMENT

The ambulatory case management program is administered by Alere's Case Management Department. High-risk members with less complex needs are identified using Health Net's advanced analytical model. The initial assessment is conducted over the telephone with a follow-up contact every other week. A medical director is involved in every case and cases are reviewed monthly or more frequently as needed. The average duration of case management engagement is one to three months. During the program, the assigned case manager thoroughly documents and strictly adheres to program follow-up schedules, comorbid assessment and interventions. In addition, intensive medical director participation in care plan development and execution is provided.

ARIZONA PALLIATIVE HOME CARE

Health Net has partnered with Arizona Palliative Home Care (AzPHC) to help manage care for seriously ill members, providing critical in-home services and helping reduce the likelihood of hospital readmission. The goal of the program is to increase the function and quality of life for the member.

The program offers concurrent and collaborative care with the member's PCP. Services include home visits from a physician or nurse practitioner, home visits from a nurse or social worker to coordinate care, assistance with personal care, and pain management consultation. AzPHC staff provide ongoing updates on in-home visits and findings to the member's PCP. Services through AzPHC are available 24 hours a day, seven days a week.

PEDIATRIC AND ADOLESCENT OVERWEIGHT ASSESSMENT AND MANAGEMENT GUIDELINES

In an effort to support busy providers with resources to care for children and adolescents at risk for overweight and obesity, Health Net offers the *Pediatric and Adolescent Overweight Assessment and Management Guidelines* flip chart. This chart gives providers practical, point-of-care guidance on the prevention and treatment of overweight and obesity. Adapted from the *Child and Adolescent Obesity Provider Toolkit* produced by the California Medical Association (CMA) Foundation and an

expert panel of health care professionals, Health Net created this flip chart to offer the latest tools and practice recommendations for providers in addressing overweight and obesity in their patients, including:

- Identification and management of body weight with routine calculation of body mass index (BMI)
- Assessment, monitoring and management of at-risk children and adolescents, including brief education and counseling tools, targeted laboratory screenings, and appropriate specialty referrals
- Cultural sensitivity considerations during the patient-provider experience
- Resource information for nutrition, physical fitness and life-skill support education, national guidelines, and weight management programs

To review the electronic version of the complete *Child and Adolescent Obesity Provider Toolkit*, visit the CMA Foundation website at www.thecmafoundation.org/programs/obesity. To obtain a copy of the *Pediatric and Adolescent Overweight Assessment and Management Guidelines* flip chart, providers may contact the Health Net Health Education Department at (800) 804-6074.

T2X

T2X is a free, social media website targeted toward teenagers and adults and developed in partnership with the University of California – Los Angeles (UCLA) Fielding School of Public Health and EPG Technologies, Inc. T2X offers professionally produced educational programs, games, quizzes, blogs, video sharing, and other interactive and participatory communication methods. The site educates and motivates participants to take healthier approaches toward important lifestyle issues, such as nutrition, fitness, stress management, substance abuse, and sexual health.

The goal of T2X is to increase participants' capacity to access and appropriately use their insurance, become more engaged in their health care and health behavior decisions, and develop pro-health attitudes. All participants ages 13 and older, regardless of health insurance status, can join for free online at www.t2x.me.

ARIZONA SMOKER'S HELPLINE

Smoking cessation support is available for Health Net Access members through the Arizona Smoker's helpline at (800) 556-6222, or online at www.ashline.org. Upon referral, members receive free help to quit tobacco use, which includes:

- Telephone-based coaching
- Online self-paced quit program
- Medication assistance

Medication assistance is available to helpline participants. Participants are eligible to receive two free weeks of nicotine patches, gum, or lozenges mailed directly to their residence. Providers may request referral forms by contacting the Health Net QI Department at AHCCCS_Notification@healthnet.com.

CLINICAL PRACTICE GUIDELINES

Health Net's evidence-based clinical practice guidelines are updated at least every other year and when new scientific evidence or national standards are published. Health Net's Medical Advisory Council (MAC) adopts the clinical practice guidelines and tools, which are available on the Health Net provider website at provider.healthnet.com under *Working with Health Net > Clinical > Medical Policies* or *Decision Power > Clinical Guidelines*. Providers who do not have access to the Internet may contact the Health Net Provider Services Center to request printed copies of these guidelines.

Guideline sources include, but are not limited to, the following:

- Disease management
  - Decision Power Clinical Insights guidelines are available for providers to quickly reference seven disease management topics, which include asthma, COPD, CAD, diabetes, chronic atrial fibrillation, primary and secondary prevention of stroke, and HF. The basis for these guidelines are provided by the following organizations:
    - Asthma and COPD: National Heart, Lung and Blood Institute (NHLBI)
    - Diabetes: American Diabetes Association (ADA)
    - CAD and HF: American Heart Association (AHA) and Institute for Clinical Systems Improvement (ICSI)

- Chronic atrial fibrillation: AHA, American College of Cardiology Foundation (ACCF) and Heart Rhythm Society (HRS)
- Stroke: AHA and American Stroke Association (ASA)

EPSDT PROGRAM

The Health Net Access Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is a comprehensive child health program of prevention, treatment, correction, and improvement (or amelioration) of physical and behavioral/mental health conditions 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 under federal law.

EPSDT Tracking Forms must be used by providers to document all age-specific, required information related to EPSDT screenings and visits. EPSDT services must be provided according to community standards of practice and the AHCCCS EPSDT and Dental Periodicity Schedules. Health Net has policies and procedures to monitor, evaluate, and improve EPSDT participation by primary care providers. For more information about the Health Net Access EPSDT Program and tracking forms, contact the Health Net Access Maternal-Child Health/EPSDT team at AZ_EPSDT_MCH@healthnet.com.

UTILIZATION MANAGEMENT PROGRAM

Health Net uses utilization management (UM) decision-making criteria that are objective and based on medical evidence to determine medical necessity, including InterQual®, Hayes Medical Technology Directory, National Medical Advisory Council Statements, and Health Net medical policies.

Health Net medical policies are available to practitioners and providers on the Health Net provider website at provider.healthnet.com. Copies of specific Health Net criteria are also available upon request by contacting Health Net Provider Services, as listed in the right-hand column of page 1 or on the last page of this update.

When a medical necessity decision results in a denial, the denial criteria are identified in the denial letter. Each denial letter explains how to obtain a copy of the criteria, a statement on the Health Net appeal process, and the name and telephone number of the Health Net provider reviewer who is available to discuss denial decisions with the requesting practitioner or provider, as required. Health Net UM staff are available by contacting Health Net Provider Services.

UM decisions are based only on appropriateness of care, service and existence of coverage. Health Net does not reward practitioners, providers or other individuals for issuing denials of coverage for health care or services. There are no financial incentives for UM decision-makers to encourage decisions that result in under-utilization.

QUALITY IMPROVEMENT INITIATIVES

Health Net Access participates in quality and performance improvement projects initiated by AHCCCS on topics that take into account comprehensive aspects of members' needs, care and services. In addition, Health Net may select and design, with AHCCCS approval, additional performance improvement projects that are specific to members' needs and are identified through internal monitoring of data for trends. Members may receive mailings or interactive voice response (IVR) calls providing them with important educational information and reminders to take action when necessary. For more information on the initiatives available, contact the Health Net QI Department via email at AHCCCS_Notification@healthnet.com.

QUALITY MEASURES AND SURVEYS

Health Net measures the quality of care and services provided to members in a number of ways, including, but not limited to, HEDIS-like performance measures for care and service, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®3) for annual assessment of member satisfaction. Health Net also monitors and tracks the minimum performance standards established by AHCCCS, and strives to meet performance measure outcomes/goals from year to year.

QUALITY AND SAFETY REPORTING

Health Net maintains the Hospital Advisor Tool, which includes performance metrics by diagnosis or procedure, such as volume, cost, mortality, and complications. The report also includes safety information from The Leapfrog Group and CMS' Hospital Quality Initiative. This Web-based tool is available to members, practitioners and providers to support informed decisions when seeking care. In addition, Health Net reports performance metrics pertaining to quality and safety of member care according to AHCCCS regulations.

BEHAVIORAL HEALTH SERVICES

As appropriate, PCPs provide care for Health Net members who have been diagnosed with depression, postpartum depression, anxiety, and attention deficit hyperactivity disorder (ADHD). In addition, upon referral by a PCP or at a member's initiative, specialty behavioral health services can be obtained through the Regional Behavioral Health Authority (RBHA).

Coordination of care is fundamental to the member's well being. PCP offices that receive information from other medical or behavioral health specialists are encouraged to document the information in the member's medical record and review relevant information with the member at his or her next primary care visit. In addition, PCPs are strongly encouraged to create a comprehensive medical record with a behavioral health section, and provide the member's behavioral health provider with information about the member's medical conditions that could affect their mental health.

Screening for Behavioral Health Conditions

Practitioners and providers are encouraged to screen members for depression and other behavioral health conditions. Various brief screening instruments are available, such as the Patient Health Questionnaire (PHQ-9) from the MacArthur Initiative on Depression and Primary Care at www.depression-primarycare.org. Other useful resources for assessing, monitoring and treating depressive symptoms are available via the *Health Net–MHN Depression Clinical Practice Guidelines* on the Health Net provider website at provider.healthnet.com. In addition, the following AHCCCS clinical toolkits are available in the provider operations manuals on the Health Net provider website in the Provider Library:

- Children – ADHD, anxiety and depression toolkits
- Adults – ADHD, anxiety, depression, and postpartum depression toolkits

Health Net reviews health risk assessments (HRAs) for behavioral health indicators and refers these members to RBHA for care.

PHARMACEUTICAL MANAGEMENT

The Health Net of Arizona Pharmacy and Therapeutics (P&T) Committee, which comprises practicing physicians, pharmacists and other health care professionals, reviews the medications on the Health Net Access *Drug List*. The Health Net Access *Drug List* serves as a reference for practitioners and providers to use when prescribing pharmaceutical products for Health Net members with pharmacy coverage. The Health Net Access *Drug List,* which is updated monthly*,* is available on the Health Net provider website at provider.healthnet.com under *Pharmacy Information.*

The Health Net of Arizona Pharmacy Department and the Health Net P&T Committee consults with external medical specialists, practicing physicians and other health care professionals to aid in the clinical decision-making process. These external reviewers, like the P&T Committee members, are licensed physicians, board-certified in the appropriate specialties, and recognized either locally or nationally for their expertise. The Health Net P&T Committee, comprised of actively practicing physicians and pharmacists, reviews medications based on clinical efficacy, safety, side effects, quality outcomes, and comparisons to existing products, and develops protocols for medications requiring prior authorization through consideration of benefit plans, step-care protocols, quantity or duration limits, benefit exclusions, potential for misuse, potential usage indications that do not meet Food and Drug Administration (FDA) criteria, experimental or off-label use, and required level of laboratory or safety monitoring.

The HNPS Strategic Development Committee may recommend cost-based tier placement in the Health Net Access *Drug List* for medications determined to be clinically equivalent by the P&T Committee.

PHARMACY CLINICAL AND SAFETY INITIATIVES

Health Net's pharmacy clinical and safety initiatives for AHCCCS focus on appropriate narcotic utilization and antibiotic use.

Appropriate Narcotic Utilization Initiative

The primary objectives of the *Appropriate Narcotic Utilization Initiative* are to ensure the proper assessment and treatment of pain through appropriate narcotic use, decrease the use of multiple short-acting narcotic products, decrease excessive intake of acetaminophen-containing products, which may lead to liver toxicity, and improve the coordination of care between prescribers.

Health Net sends targeted practitioners and providers a mailing, including a cover letter, physician reference sheet on pain management and member profiles. Member profiles encourage physicians to review their patients' medication history and promote appropriate utilization through coordination of care. Health Net will send targeted members a letter and educational flyer highlighting the safe and correct use of acetaminophen and acetaminophen-containing prescription medications. Additional services and resources will be offered through MHN, the Health Net Decision Power program and various county programs.

Antibiotic Initiative

The primary objective of the *Antibiotic Initiative* is to promote judicious prescribing of antibiotic medications by providing a toolkit to assist practitioners in managing antimicrobial therapy.

In collaboration with the Alliance Working for Antibiotic Resistance Education (AWARE), select providers receive a toolkit developed by the AWARE QI Collaborative, including information on upper respiratory tract infection, pediatric pharyngitis, and acute adult bronchitis; flu prevention guideline summaries; and member educational materials. Providers may download the toolkit components from the AWARE website at www.aware.md.

NOTIFICATION OF ACCESS STANDARDS

In accordance with AHCCCS standards, Health Net has established access and availability standards that are reviewed and revised annually as needed, and strive to ensure compliance with all applicable state, federal and regulatory requirements. Members have access to a comprehensive provider network and timely access to care.

Health Net is committed to monitoring the network and evaluating whether members have sufficient access to practitioners and providers who meet members' care needs. These include timeliness standards for waiting times for regular and routine appointments, urgent care appointments and after-hours care, as well as provisions for appropriate back-up for absences. The standards are reviewed annually against applicable state and federal regulations and mandates, and are revised as needed. Health Net highly recommends that providers review these periodically. Additionally, Health Net has recently revised and released updated versions of the after-hours script templates.

The complete set of standards and revised after-hours script templates are available on the Health Net provider website at provider.healthnet.com in the Provider Library. Providers who do not have access to the Internet may contact Health Net Provider Services to request printed copies of these standards and after-hours script templates.

RIGHTS AND RESPONSIBILITIES

Member Rights and Responsibilities

Health Net is committed to treating members in a manner that respects their rights, recognizes their specific needs and maintains a mutually respectful relationship. In order to communicate this commitment, Health Net has adopted the following member rights and responsibilities. These rights and responsibilities apply to members' relationships with Health Net, its practitioners and providers, and all other health care professionals providing care to its members. They are available on the Health Net provider website at provider.healthnet.com or upon request by contacting Health Net Provider Services.

Member Rights

A Health Net Access member has the right to:

- Be treated with respect and recognition of the their dignity and right for privacy
- Request a copy of the Notice of Privacy Practices at no cost
- Not be discriminated against based on race, ethnicity, national origin, religion, sex, age, intellectual or physical disability, sexual orientation, genetic information, 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 PCP from Health Net's participating PCPs
- Participate in decision-making regarding his or her 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 the member understands
- Know about providers who speak languages other than English

- Be provided with information regarding grievances, appeals and requests for hearings
- Complain about the managed care organization
- Have access to review his or her medical records in accordance with applicable federal (Title 45 CFR 164.524) and state laws
- Have the right to request and receive annually, at no cost, a copy of his or her medical records
- Receive a response from Health Net within 30 days of the member's request for a copy of medical records (response may be the copy of the medical record or written denial that includes the basis for the denial and information on how to seek review of the denial in accordance with 45 CFR Part 164)
- Have the right to amend or correct his or her medical records as specified in 45 CFR 164.526
- Request information on whether Health Net has physician incentive plans (PIPs) that affect the use of referral services, types of compensation arrangements, whether stop-loss insurance is required, and the right to a summary of member survey results, in accordance with PIP regulations

Member Responsibilities

A Health Net Access member has the responsibility to:

- Provide, to the extent possible, information needed by professional staff in caring 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 18 years of age or younger
- Protect and keep his or her ID card. Misuse of the ID card, including loaning, selling or giving it to others could result in loss of the member's eligibility and/or legal action

POTENTIAL QUALITY OF CARE ISSUE REFERRALS

In compliance with regulatory requirements and to ensure members receive the highest quality of care, Health Net monitors and evaluates potential quality of care issues (PQIs) involving Health Net members through the Health Net QM Department. PQIs that are reportable to Health Net include, but are not limited to, hospital-acquired conditions (HACs), health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs). Providers are expected to report any preventable condition to Health Net. In addition, providers are required to report any suspected abuse, neglect, exploitation or unexpected death to the appropriate regulatory agency and the Health Net QM Department. The PQI Referral form is available for providers to fax reports of potential or suspected deviation from standards of care that cannot be justified without additional review or investigation. Issues identified as member appeals or grievances, including member complaints, may continue to be referred to Health Net's Member Services or Member Appeals and Grievances departments for appropriate resolution.

Potential Quality Issue Referral Form

Providers may access the PQI Referral form in the Provider Library on the Health Net provider website at provider.healthnet.com under *Forms*, then search for *Potential Quality Issue Referral Form*.

Providers can complete the PQI Referral form and submit it to the QM Department via confidential fax at (877) 808-7024, preferably within one business day of the incident. The indicators on the form refer to an event or trigger. Use the broad general category lists to identify the potential quality of care issue, or use the *Other* category to describe the incident. Additional completion instructions are provided on the form.

MEMBER APPEALS

A member or a member representative who believes that a determination or application of coverage is incorrect has the right to file an appeal within 60 days from the date of the Notice of Action (NOA). Health Net responds to appeals and grievances as follows:

- Standard appeals – acknowledged within five business days and resolved within 30 calendar days. Expedited appeals when waiting for certification could seriously harm the member's health – acknowledged within one calendar day and resolved within three business days
- Grievances (an expression of dissatisfaction about any matter other than an action) – acknowledged within five business days and resolved within 10 business days, absent extraordinary circumstances. However, resolution must not exceed 90 days. There is no time limit for filing a grievance

A member who received an unfavorable NOA resolution letter may ask for a state fair hearing. Members have 30 days from the date they received the NOA resolution letter to request a state fair hearing. The member must request a state fair hearing in writing to Health Net. State fair hearings are only available for appeals and are not available for grievances.

PRIVACY AND CONFIDENTIALITY

Health Net members' protected health information (PHI), whether it is written, oral or electronic, is protected at all times and in all settings. Health Net practitioners and providers can only release PHI without authorization when:

- Needed for payment
- Necessary for treatment or coordination of care
- Used for health care operations (including, but not limited to, HEDIS reporting, appeals and grievances, UM, QI, and disease or care management programs)
- Where permitted or required by law

Any other disclosure of a Health Net member's PHI must have a prior, written member authorization. Health Net practitioners and providers must ensure that only authorized people with a need-to-know have access to a member's PHI.

Special authorization is required for uses and disclosures involving sensitive conditions, such as psychotherapy notes, HIV/AIDS, behavioral health issues, or substance abuse. To release a member's PHI regarding sensitive conditions, Health Net practitioners and providers must obtain prior written authorization from the member (or authorized representative), which states the information specific to the sensitive condition that may be disclosed.

MEDICAL RECORD DOCUMENTATION STANDARDS

Health Net has established standards for the administration of medical records that ensure medical records conform to good professional medical practice, support health management and permit effective member care. A good medical record management system not only provides support to clinical practitioners and providers in the form of efficient data retrieval, but also makes data available for statistical and quality-of-care analyses.

The medical record serves as a detailed analysis of the member's history, a means of communication to assist the multidisciplinary health care team in providing quality medical care, a resource for statistical analysis, and a potential source of defense support information in a lawsuit. It is the provider's responsibility to ensure not only completeness and accuracy of content, but also the confidentiality of the health record. Health Net requires that the provider adhere to the standards for maintaining member medical records and to safeguard the confidentiality of medical information.

Providers are responsible for responding to requests for information while protecting the confidentiality interests of Health Net members. All providers must have policies and procedures that address confidentiality and the consequences of improper disclosure of member PHI. Refer to the Medical Records Guidelines topic in the Health Net provider operations manuals, available online through the Health Net provider website at provider.healthnet.com, to review specific levels of medical record security that must be addressed by provider policies and procedures governing the confidentiality of medical records and the release of member PHI.

Health Net's QM Department monitors medical record documentation compliance and implements appropriate interventions to improve medical record keeping. Medical record guidelines are available through the Health Net provider website at provider.healthnet.com or upon request by contacting Health Net Provider Services.

ADDITIONAL INFORMATION

More extensive information on all the programs described in this update is available on the Health Net provider website at provider.healthnet.com. Providers who do not have access to the Internet may request printed copies of provider materials by contacting the Health Net Provider Services Center. A complete copy of Health Net's QI program description is available on request by sending an email to the QI Department at AHCCCS_Notification@healthnet.com.

A user name and password are required to use the provider website. On the site, select the *Provider* tab at the top of the home page and select *Register Now* in the middle of the page. Each practitioner or provider office can designate a delegated

administrator (usually an information technology, office or security manager) who is responsible for opening accounts and monitoring employee-level access to provider information on the site.

Providers can visit the QI Corner on the Health Net provider website at provider.healthnet.com under *Working with Health Net > Quality > Quality Improvement Corner* to view Health Net's quality outcomes and progress towards goals. The QI Corner also contains tools and materials that can assist providers in delivering care that upholds the standard and performance that members expect.

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

[1] 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. Also, it is not 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. But 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.

[2] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

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

PROVIDER*Update*

CONTRACTUAL | SEPTEMBER 11, 2014 | UPDATE 14-405 | 1 PAGE

Health Net Access™

Non-Discrimination and Right to Advocate for Members

The Arizona Health Care Cost Containment System (AHCCCS) has specified requirements for Health Net Access and its providers regarding non-discrimination and providers' rights to advise and advocate on a member's behalf.

NOTICE OF NON-DISCRIMINATION

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

PROVIDER RIGHT TO ADVOCATE FOR MEMBERS

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

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

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center at (888) 788-4408.

Discover Helpful Tools to Support Your Office

The Provider Library online at provider.healthnet.com allows participating providers to quickly access pertinent information to assist in their everyday interaction with Health Net. The Provider Library includes operations manuals, communications (updates and letters), Online News articles, forms, Health Net contact information, and more.

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- Physicians
- Medical Groups/IPAs
- Hospitals
- Ancillary Providers

PROVIDER SERVICES

az_internetproviderinquiries@healthnet.com
(888) 788-4408
www.healthnet.com

NATIONAL PROVIDER COMMUNICATIONS

provider.communications@healthnet.com
fax (800) 937-6086

PROVIDER*Update*

Health Net Access™

CONTRACTUAL | AUGUST 29, 2014 | UPDATE 14-384 | 1 PAGE

Claims Submission Information for Health Net Access

As a reminder, Health Net Access providers must use the correct payer identification (ID) code for electronic claim submission, and the correct mailing addresses for submitting paper claims, additional information and claim disputes.

ELECTRONIC CLAIM SUBMISSION

Providers must submit electronic claims for Health Net Access members using payer ID 38309. For questions regarding electronic claim submissions, providers may contact Health Net's electronic data interchange (EDI) support team via email at edi.support@healthnet.com or by telephone to Health Net's dedicated EDI line at (866) 334-4638, option 4.

SUBMISSION OF PAPER CLAIMS AND ADDITIONAL INFORMATION

Health Net encourages providers to submit claims electronically; however, Health Net does accept paper claims submitted on a current CMS-1500 or UB-04 form.

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

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

PROVIDER CLAIM DISPUTES

Health Net Access providers must send claim disputes to:

Health Net Access, Inc.
Attention: Provider Appeals
PO Box 10340
Van Nuys, CA 91410-0340

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

Update Your Info Online

Is your demographic information current for Health Net provider directories and the online ProviderSearch function? Submit updates and corrections, including information regarding practice locations, provider names, languages spoken at the practice, and office hours, on the provider website at provider.healthnet.com by selecting *My Account > Update Provider Information.*

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PROVIDER*Update*

CONTRACTUAL | AUGUST 22, 2014 | UPDATE 14-370 | 1 PAGE

Health Net Access™

New Nonemergency Transportation Company for Health Net Access

Effective August 31, 2014, Total Transit is the new nonemergency transportation company for Health Net Access members. 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.

To arrange for nonemergency transportation services for Health Net Access members, contact Health Net Access by telephone at (888) 788-4408.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

Update Your Info Online

Is your demographic information current for Health Net provider directories and the online ProviderSearch function? Submit updates and corrections, including information regarding practice locations, provider names, languages spoken at the practice, and office hours, on the provider website at provider.healthnet.com by selecting *My Account > Update Provider Information.*

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fax (800) 937-6086

PROVIDER*Update*

CONTRACTUAL | AUGUST 21, 2014 | UPDATE 14-373 | 1 PAGE

Health Net Access™

Medical Policy Clarification for FibroScan and FibroSure

Health Net's medical policy titled FibroSpect®, HCV-FibroSure™, ActiTest®, states that FibroScan® and FibroSure are considered investigational for determining liver fibrosis. However, there is an exception for Health Net Access members.

The Arizona Health Care Cost Containment System (AHCCCS) prior authorization criteria for the treatment of hepatitis C lists FibroScan and FibroSure as acceptable methods for assessing liver fibrosis. Therefore, Health Net Access medical program policy allows for the use of FibroScan and FibroSure as medically appropriate diagnostic tests for determining liver fibrosis for members with hepatitis C.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

Update Your Info Online

Is your demographic information current for Health Net provider directories and the online ProviderSearch function? Submit updates and corrections, including information regarding practice locations, provider names, languages spoken at the practice, and office hours, on the provider website at provider.healthnet.com by selecting *My Account > Update Provider Information.*

THIS UPDATE APPLIES TO **HEALTH NET ACCESS (AHCCCS)** PROVIDERS:

- Physicians
- Medical Groups/IPAs
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- Ancillary Providers

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www.healthnet.com

NATIONAL PROVIDER COMMUNICATIONS

provider.communications@healthnet.com
fax (800) 937-6086

Health Net Access™

Webinar *for* AHCCCS *Providers*

Register today for Health Net's online training

Health Net Provider Network Services invites you to an upcoming webinar for Arizona Health Care Cost Containment System (AHCCCS) providers. This no-cost session is designed for Health Net Access (AHCCCS) primary care physicians (PCPs), obstetricians and gynecologists (OB/GYNs), specialist and dental providers, and their staff, including billing teams.

Date:

Wednesday, September 3, 2014
11:00 a.m. – 12:30 p.m., Mountain time (MT)

Registration information:

Email your response to
Timothy.S.Bennett@healthnet.com
by Friday, August 29, 2014.

Health Net will respond with a link for you to complete the registration process.

Availability is limited; register soon!

Who should attend?

PCPs, OB/GYNs, specialists, dental providers, staff, billers

Topics include:

- Behavioral health treatment
- Community solutions
  - Community resources for AHCCCS members
  - Health education materials for Health Net Access members
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Maternal Child Health (MCH)
- Potential quality of care issues (PQIs)
  - What are the different types of PQIs
  - What you should report
  - How to report PQIs

If you are unable to participate in the webinar, materials will be available on the Health Net website at provider.healthnet.com under *Working with Health Net > Regulatory > Health Net Access*, or you may request them via email to the Health Net Quality Improvement Department at AHCCCS_Notification@healthnet.com.

PROVIDER*Update*

Health Net®

NEWS & ANNOUNCEMENTS | AUGUST 8, 2014 | UPDATE 14-344 | 2 PAGES

Pertussis Epidemic in Arizona

In 2013, Arizona had the highest rates of reported pertussis since the 1950s[1]. Infants are particularly susceptible to complications from this disease, including hospitalization and death, because they are unable to receive the pertussis vaccination (DTaP) until age two months. Children ages two months to six years should receive the DTaP vaccination. Children ages seven and older, adolescents and adults should receive the pertussis booster vaccination (Tdap) to protect infants with whom they come in contact.

BEST PRACTICES GUIDELINES

Health Net and the Arizona Department of Health Services (ADHS) recommend the following best practices for preventing pertussis:

- Encourage pregnant women to receive the Tdap vaccine during the third trimester of every pregnancy, regardless of the number of doses of the Tdap vaccine that were received[2]
- Adolescents and adults need a single dose of Tdap[3]
- Tdap can be given regardless of the time interval since the last tetanus toxoid or diphtheria toxoid containing vaccine
- When tetanus vaccine (Td) is indicated for catch-up vaccination or wound management, individuals ages seven and older should receive a Tdap in place of a Td if they have not already received a Tdap[4]
- All healthcare personnel should receive a dose of Tdap[5]

RESOURCES

The following resources provide scripts to discuss Tdap vaccinations with pregnant patients, training and patient education:

- American College of Obstetricians and Gynecologists (ACOG) toolkit: www.immunizationforwomen.org/resources/acog_resources
- Training modules on proper vaccine storage, handling and immunization techniques: http://eziz.org/eziz-training/
- Patient education materials:
  - *Whooping Cough: What You Need to Know*: http://bit.ly/1023_6-14 (Spanish: http://bit.ly/1023S_6-14)
  - *Immunizations for a Healthy Pregnancy*: http://bit.ly/887_6-14 (Spanish: http://bit.ly/887S6-14)
  - *Expecting? Protect Your Baby from Whooping Cough*: http://bit.ly/1qq9EZn (Spanish: http://bit.ly/UK2ofW)

Additional information and resources are available on the CDC website at www.cdc.gov/pertussis and the ADHS website at http://azdhs.gov/phs/immunization.

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- ● Physicians
- ● Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

LINES OF BUSINESS:

- ● Advantage Platinum (HMO)
- ● Advantage Platinum (PPO, POS)
- ● Medicare Advantage (HMO)
- ● Health Net Access (AHCCCS)

PROVIDER SERVICES

az_internetproviderinquiries@healthnet.com
HMO, PPO, POS, Medicare Advantage – (800) 289-2818
Health Net Access – (888) 788-4408
CommunityCare Health Insurance Marketplace – (888) 926-1870
www.healthnet.com

NATIONAL PROVIDER COMMUNICATIONS

provider.communications@healthnet.com
fax (800) 937-6086

BILLING AND REIMBURSEMENT

Providers should use the required 2014 CPT codes[6] listed below for the Tdap vaccine when submitting claims, as appropriate. Providers must submit both Tdap vaccine and vaccine administration codes. Reimbursement for the vaccine is according to the provider's *Provider Participation Agreement* (*PPA*) with Health Net.

Tdap Vaccine	Vaccine Administration	
	AGE 18 AND UNDER	**OVER AGE 18**
90715	90460-90461	90471-90472

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center at:

Line of Business	Telephone Number	Email Address
HMO, PPO, POS, & MEDICARE ADVANTAGE	(800) 289-2818	AZ_InternetProviderInquiries@healthnet.com
HEALTH NET ACCESS	(888) 788-4408	
COMMUNITYCARE HEALTH INSURANCE MARKETPLACE	(888) 926-1870	

[1] Arizona Department of Health Services, Division of Public Health Services. (2014). Retrieved from website: http://azdhs.gov/phs/immunization/documents/healthcare-professionals/letter-tdap-pertussis-vaccine.pdf

[2] Committee Opinion No. 566. American College of Obstetricians and Gynecologists (ACOG). *Update on immunization and pregnancy: tetanus, diphtheria, and pertussis vaccination*. Obstet Gynecol 2013;121:1411–4.

[3] CDC. *Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis (Tdap) Vaccine from the Advisory Committee on Immunization Practices*, 2010. MMWR. January 14, 2011.

[4] CDC. *Preventing Tetanus, Diphtheria, and Pertussis Among Adults: Use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine*. MMWR, December 15, 2006.

[5] CDC. *Immunization of Healthcare Personnel*. MMWR Recommendations and Reports. November 25, 2011.

[6] CPT codes were taken from the 2014 CPT Plus! 2014 code handbook.

Update Your Info Online

Is your demographic information current for Health Net provider directories and the online ProviderSearch function? Submit updates and corrections, including information regarding practice locations, provider names, languages spoken at the practice, and office hours, on the provider website at provider.healthnet.com by selecting *My Account > Update Provider Information.*

Health Net, Inc.

PROVIDER*Update*

CONTRACTUAL | JULY 22, 2014 | UPDATE 14-301 | 3 PAGES

Medical Policies – 2nd Quarter 2014

This provider update includes a listing of new and updated Health Net medical policies approved by the Health Net National Medical Advisory Council (MAC) in the second quarter of 2014. For a complete description of new and updated medical policies, visit the Health Net provider website at provider.healthnet.com and select *Working with Health Net > Medical Policies*.

PURPOSE OF HEALTH NET MEDICAL POLICIES

Medical policies provide guidelines for determining medical necessity for specific procedures, equipment and services. All services must be medically necessary to be eligible for benefit coverage, unless otherwise defined in the member's benefits contract. The determination for coverage is also based on all of the terms of the individual member's benefits contract, including, but not limited to, eligibility at the time of service and description of covered benefits, limitations and exclusions. In some cases, legal or regulatory mandate requirements may be applicable and may prevail over medical policy. To the extent there are any conflicts between medical policy guidelines and applicable benefit contract language, the benefit contract language prevails. Medical policy is not intended to override the member *Evidence of Coverage* or the health insurance policy that defines the member's benefits, nor is it intended to provide medical advice or dictate to providers how to practice. If required, prior authorization must be obtained before services are rendered.

New Policies

Medical Policy	Policy Statement
DENTAL ANESTHESIA	This policy addresses the medical indications of general anesthesia, moderate and conscious deep sedation, or monitored anesthesia care provided for dental services in a hospital or surgery center as medically necessary for members who require the skilled services and monitoring provided in these facilities in order to ensure that health is not compromised. Note: This is subject to benefit plan language and governed by state mandates. Refer to the applicable benefit plan document to determine availability and terms and conditions of coverage

THIS UPDATE APPLIES TO:

- Physicians
- Participating Physician Groups/ Medical Groups/IPAs
- Hospitals
- Ancillary Providers

STATE:

- Arizona
- California
- Oregon/Washington

LINES OF BUSINESS:

- All

ARIZONA

az_internetproviderinquiries@healthnet.com
HMO, PPO, POS, Medicare Advantage – (800) 289-2818
Health Net Access – (888) 788-4408
CommunityCare Health Insurance Marketplace – (888) 926-1870

CALIFORNIA

provider_services@healthnet.com
HMO/POS, PPO & EPO – (800) 641-7761
Medicare Programs – (800) 929-9224
Cal MediConnect:
Los Angeles County – (855) 464-3571
San Diego County – (855) 464-3572
Medi-Cal – (800) 675-6110
CommunityCare Covered California – (888) 926-2164

OREGON/WASHINGTON

EPO, POS, PPO, & CommunityCare – (888) 802-7001
Medicare Advantage HMO/PPO – (888) 445-8913
CommunityCare Cover Oregon – (888) 926-2480

www.healthnet.com

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provider.communications@healthnet.com
fax (800) 937-6086

New Policies, continued

Medical Policy	Policy Statement
ENDOTHELIAL KERATOPLASTY (EK)	Various types of EK are considered medically necessary for the treatment of endothelial dysfunction and other diagnoses noted in the policy. Femtosecond laser-assisted corneal endothelial keratoplasty (FLEK) or femtosecond and excimer laser-assisted endothelial keratoplasty (FELEK) are considered investigational
LAPAROSCOPIC ULTRASOUND-GUIDED RADIOFREQUENCY ABLATION OF UTERINE FIBROIDS	Laparoscopic ultrasound-guided radiofrequency ablation of uterine fibroids (Acessa™) is considered investigational as studies to date have been small, short-term and limited. Further comparative studies are needed
OUTPATIENT CARDIAC REHABILITATION	Policy developed to address indications for medically supervised outpatient cardiac rehabilitation
OUTPATIENT TOTAL JOINT REPLACEMENT	Minimally invasive knee and hip joint replacement may be performed in an outpatient setting in specific facilities that have been contractually approved by Health Net to perform these procedures in the outpatient setting

Updated Policies

Medical Policy	Change
BONE GROWTH STIMULATORS ELECTRICAL AND ULTRASONIC	Added that fixation devices made from magnetic materials may compromise the effects of electric bone growth stimulators
CONTINUOUS GLUCOSE MONITORING	Added “Type II diabetics who require insulin” to the policy statement for either short- or long-term use
DEEP BRAIN STIMULATION FOR MOVEMENT DISORDERS	Added deep brain stimulation for Meige’s syndrome should be reviewed on a case-by-case basis and would be considered medically necessary if refractive to all medical treatment
FIBROSPECT®, HCV-FIBROSURE™, ACTITEST®	Added magnetic resonance elastrography (MRE) as investigational at this time when used to stage and detect liver fibrosis because of a paucity of peer-reviewed literature. In addition, there were no consistent means to stage liver fibrosis with MRE
GENETIC TESTING FOR TAY-SACHS	Added as medically necessary for carrier screening for Tay-Sachs disease (TSD) for all Ashkenazi Jews, French Canadian or Cajun descent and those with a family history consistent with TSD, who are pregnant or considering pregnancy
HIV TESTING AND COUNSELING	Added the updated U.S. Preventive Services Task Force (USPSTF) recommendations for 2013 to screen for HIV infection in adolescents and adults ages 15 to 65. Younger adolescents and older adults who are at increased risk should also be screened
IMPLANTABLE CARDIAC EVENT MONITORS	Added Reveal LINQ™, a Food and Drug Administration (FDA) newly approved insertable cardiac monitor (ICM), also known as an insertable loop recorder (ILR), as medically necessary as it is similar to other devices
INTERSPINONOUS PROCESS DECOMPRESSION SYSTEM	Added Coflex® Interlaminar Stabilization™ device as investigational and updated codes

Updated Policies, continued

Medical Policy	Change
INTRAOPERATIVE RADIATION THERAPY (IORT)	Based on National Comprehensive Cancer Network (NCCN) recommendations, added IORT as investigational for cervical, uterine and endometrial cancer. Studies were done to reflect these changes
MOBILE OUTPATIENT CARDIAC TELEMETRY (MCOT)	Removed requirement of Holter monitor prior to MCOT when symptoms occur infrequently, and for continuous loop monitor for 30 days prior to MCOT, when the episodes do not last long enough to activate the monitor reliably; or the individual is unable to manage the technical requirements of a standard loop recorder
MOLECULAR TUMOR MARKERS FOR NON-SMALL CELL LUNG CANCER (NSCLC)	Based on NCCN recommendations, added epidermal growth factor receptor (EGFR) mutation testing should be done as part of a multiplex mutation screening assay or next-generation sequencing (NGS). Testing for ALK gene rearrangements can be done with fluorescence in situ hybridization (FISH) or NGS. Added VeriStrat® test for individuals with advanced NSCLC who are being considered for treatment with an EGFR tyrosine-kinase inhibitor (TKI) as investigational
PHARMACOGENETIC TESTING	Added the following as investigational: • HLA-B*1502 genotyping in patients of non-Asian ethnicities for whom treatment with carbamazepine (Tegretol®), or with phenytoin (Dilantin®) are being considered; or in patients for whom treatment with lamotrigine (Lamictal®) is being considered • Genotyping for HLA-B variants other than HLA-B*1502 in patients for whom treatment with carbamazepine (Tegretol), phenytoin (Dilantin), or lamotrigine (Lamictal) is being considered
STEM CELL TRANSPLANTATIONS IN ADULT PATIENT	Added stem cell harvest adequate for two transplants, if a multiple myeloma patient is a candidate for transplant (NCCN 2014 Guidelines)
TANDEM STEM CELL TRANSPLANTS IN THE ADULT PATIENT	Clarified policy statement noting that tandem stem cell transplants (SCT) can be done with autologous stem cells as recommended by NCCN guidelines
THERASPHERE, SIR-SPHERE	Added that TheraSphere® is approved under the Humanitarian Device Exemption (HDE) for radiation treatment or as a neoadjuvant to surgery or transplantation in patients with unresectable hepatocellular carcinoma (HCC) who can have placement of appropriately positioned hepatic arterial catheters
TRANSCATHETER AORTIC VALVE REPLACEMENT (TAVR)	Added TAVR using Medtronic CoreValve® as medically necessary when criteria are met
TUMOR MARKERS FOR CANCER	Added Afirma® thyroid fine-needle aspiration (FNA) analysis as medically necessary for adults with thyroid nodules at least one centimeter in size, that are indeterminate and who are being evaluated for the possibility of a thyroid malignancy. Added isocitrate dehydrogenase (IDH) testing medically necessary for glioma in limited scenarios

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center at provider.healthnet.com or as listed in the right-hand column on page 1.

PROVIDER*Update*

Health Net®

CONTRACTUAL | JULY 21, 2014 | UPDATE 14-305 | 2 PAGES

Interpreter Services and Cultural Training

Health Net offers participating physicians, medical groups, ancillary providers, and members 24-hour access to telephonic interpreter services. Additionally, Health Net offers in-person interpreter services, as well as sign language assistance, during business hours at no cost. These services feature the following:

- Qualified interpreters training on health care terminology and a wide range of interpreting protocols and ethics
- Support to address common communication challenges across cultures

This communication describes Health Net interpreter services and lists access information.

INTERPRETER SERVICES

Information regarding telephonic interpreter services is available by contacting the Provider Services Center at (888) 788-4408, 24 hours a day, seven days a week. To have an in-person interpreter or sign-language interpreter present onsite, providers must schedule it no less than three to five business days prior to the member's appointment. In-person interpreters are available between 7:00 a.m. and 6:00 p.m., Monday through Friday.

When calling, providers must have the following information available:

- Member name
- Member Health Net identification (ID) number
- Appointment date and time, if necessary

CULTURAL AND LINGUISTIC APPROPRIATENESS

Health Net provides the following to comply with mandated cultural and linguistic appropriateness standards:

- Oral language services that include answering questions and providing assistance in any non-English language
- Upon request, Spanish translation of vital documents that provide information on eligibility and how to participate in the plan
- A statement indicating how to access language services in any applicable non-English language

PROVIDER RESPONSIBILITIES

Participating providers may use Health Net's interpreter services to provide interpreters to members who require or request them. Participating providers must ensure that language services meet the established requirements as follows:

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- ● Physicians
- ● Medical Groups/IPAs
- ○ Hospitals
- ● Ancillary Providers

LINES OF BUSINESS:

- ○ Advantage Platinum (HMO)
- ○ Advantage Platinum (PPO, POS)
- ○ Medicare Advantage (HMO)
- ● Health Net Access (AHCCCS)

PROVIDER SERVICES

az_internetproviderinquiries@healthnet.com
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fax (800) 937-6086

- Ensure that limited-English proficient (LEP) members are not subject to unreasonable delays in the delivery of services
- Not require or encourage members to use family members or friends as interpreters. Health Net strongly discourages the use of minors as interpreters, unless used in an emergency situation
- Provide interpreter services at no cost to members
- Extend same participation opportunities in programs and activities to all members regardless of their language preferences
- Provide services to LEP members that are as effective as those provided to others
- Record the language needs of each member, as well as the member's request or refusal of interpreter services, in his or her medical record
- Advise members that they may file grievances with Health Net if their language needs are not meet

PROVIDERS DELEGATED FOR UTILIZATION MANAGEMENT ONLY

In addition to the above, providers delegated for utilization management (UM) must comply with the following:

- Translation services – Upon request, provide Health Net with the documents sent to members in a timely manner. If a Health Net member requests translation of an English document that was produced by an ancillary provider on Health Net's behalf, the provider must refer the member to the Health Net Customer Contact Center (CCC) telephone number listed on the member's ID card. When Health Net's CCC receives the member's request, Health Net contacts the provider requesting a copy of the specific English document for translation. The provider must submit the document within 48 hours of Health Net's request
- Notice of Language Assistance (NOLA) – Include Health Net-specific NOLA, which advises members that they can receive support in their preferred language, with vital documents distributed to Health Net members (for example, UM denial and delay notices, and claims notices that require member action). A sample notice is available in the provider operations manuals on the Health Net provider website at provider.healthnet.com. From the Provider Library, choose the appropriate audience and product line, and select *Forms > Notice on the Availability of Language Assistance*

CULTURAL COMPETENCY TRAINING

All participating providers are required to take cultural competency training. The United States Department of Health and Human Services' Office of Minority Health (OMH) offers a computer-based training (CBT) program on cultural competency for health care providers. This program was developed to furnish providers with competencies enabling them to better treat the United States' increasingly diverse population. For more information, refer to the OMH Think Cultural Health website at https://cccm.thinkculturalhealth.hhs.gov. Health Net does not sponsor or maintain the OMH CBT or website.

ADDITIONAL INFORMATION

Providers who would like information on cross-cultural communication, health literacy or accessing interpreter services may contact Health Net's Cultural and Linguistic Services Department by email at Cultural.and.Linguistic.Services@healthnet.com or by telephone at (800) 977-6750.

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

Provider-Relevant Articles Online

Access informative Online News articles today by logging in to provider.healthnet.com. Select the rotating graphic to read or print the articles of interest. Health Net posts new articles each week that cover a variety of topics, such as health plan updates, administrative procedure reminders, quality improvement tips, and health care initiatives.

PROVIDER*Update*

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CONTRACTUAL | JULY 1, 2014 | UPDATE 14-285 | 1 PAGE

EPSDT Program Reminder

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a comprehensive child health program to treat, correct and improve the physical and mental health of Health Net Access members under age 21.

SCHEDULING REMINDER

Health Net Access members under age 21 should have routine wellness check-ups, dental screenings and necessary immunizations based on the Arizona Health Care Cost Containment System (AHCCCS) EPSDT Periodicity Schedule, available under *EPSDT Services – Exhibit 430-1* on the AHCCCS website at www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap400.pdf.

Health Net requests that providers contact their Health Net Access members who are due for any preventive health care services to schedule recommended immunizations and well-child visits.

HPV VACCINES

Human papillomavirus (HPV) vaccines are routinely recommended for boys and girls ages 11 and 12; however, the vaccine series can be started beginning at age 9.

GIFT CARD DRAWING

After each well-child or immunization visit, members are eligible to enter a drawing for a $50 gift card. Parents or guardians may contact Health Net Access by telephone at (800) 804-6074 to enter the drawing.

MISSED APPOINTMENT

Health Net assists providers with Health Net Access members who fail to show up for appointments. Complete the Health Net Access Missed Appointment/No Show Log, available online in the *Forms* section of the Provider Library on the Health Net provider website at provider.healthnet.com, and fax it to (602) 794-1803. Health Net will contact members' parents or guardians to remind them about the importance of a well-child visit and required immunizations.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- ● Physicians
- ● Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

LINES OF BUSINESS:

- ○ Advantage Platinum (HMO)
- ○ Advantage Platinum (PPO, POS)
- ○ Medicare Advantage (HMO)
- ● Health Net Access (AHCCCS)

PROVIDER SERVICES

az_internetproviderinquiries@healthnet.com
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NATIONAL PROVIDER COMMUNICATIONS

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PROVIDER*Update*

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CONTRACTUAL | JUNE 20, 2014 | UPDATE 14-282 | 1 PAGE

EPSDT Tracking Form Requirements

Effective April 1, 2014, the Arizona Health Care Cost Containment System (AHCCCS) revised the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) tracking forms. All Health Net participating providers who provide preventive health care services to Health Net Access members under age 21 must begin using the revised age-appropriate EPSDT tracking forms immediately to document well-child visits.

Current EPSDT tracking forms and completion instructions are available on the AHCCCS website at www.ahcccs.gov/shared/Downloads/Medical PolicyManual/AppendixB.pdf and on the Health Net provider website at provider.healthnet.com in the Provider Library, under *Forms > EPSDT Tracking Forms*.

Providers must use only AHCCCS EPSDT tracking forms to document well-child visits; paper form substitutes are not accepted. However, providers may utilize an electronic health record system, as long as the electronic documentation includes all elements present on the AHCCCS EPSDT tracking forms. Providers must file a copy of the EPSDT tracking form in the member's medical record. Providers may submit either a copy of the medical record or the EPSDT tracking forms to the Health Net Encounter Department via fax at (916) 935-4476 or by mail to:

Health Net Encounter Department
PO Box 419071
Rancho Cordova, CA 95741

DEVELOPMENTAL SCREENING TOOLS AND TRAINING

EPSDT visits must include a developmental screening for members from birth through age three during the 9-, 18- and 24-month check-ups. AHCCCS recommends using one of the following developmental screening tools:

- Parent's Evaluation of Developmental Status (PEDS)
- Ages and Stages Questionnaire (ASQ)
- Modified Checklist for Autism in Toddlers (M-CHAT)

In accordance with the American Academy of Pediatrics (AAP), providers are required to complete training on the use and scoring of the developmental screening tools. Providers must submit a copy of their completed certificates to the Health Net Access EPSDT Program via fax at (855) 349-3921.

BILLING

Effective April 1, 2014, providers who have completed an AHCCCS-recommended training may be reimbursed for utilizing the developmental screening tool as part of the EPSDT visit. Billing for the developmental screening must be submitted separately using CPT-4 procedure code 96110 with modifier EP. Providers must fax the EPSDT tracking form, development screening tool and CMS-1500 to Health Net at (855) 349-3921 for reimbursement.

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center as listed in the right-hand column.

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- ● Physicians
- ● Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

LINES OF BUSINESS:

- ○ Advantage Platinum (HMO)
- ○ Advantage Platinum (PPO, POS)
- ○ Medicare Advantage (HMO)
- ● Health Net Access (AHCCCS)

PROVIDER SERVICES

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NEWS & ANNOUNCEMENTS | MAY 20, 2014 | UPDATE 14-197 | 1 PAGE

2014 Provider Teleconferences

In 2014, Health Net Access is offering a variety of educational teleconferences to physicians, case managers, nurses, and other staff who work with Health Net Access members. Health Net Access offers continuing education hours to nurses[1], and St. Joseph's Hospital and Medical Center offers continuing medical education (CME)[2] credits. Topics, dates and times are as follows:

Topic	Date[3]	Time (Pacific)
Reducing Readmissions	June 25, 2014	12:00–1:00 p.m.
Strategies to Address Diabetes and Heart Health	August 13, 2014	12:00–1:00 p.m.
The Link Between Oral Health and Medical and Mental Illness	October 1, 2014	10:00–11:00 a.m.

Health Net Access encourages provider attendance and engagement at these educational teleconferences to address health care gaps, improve performance measures and fulfill interventions outlined in Arizona Health Care Cost Containment System (AHCCCS)-directed projects, such as the *Reducing Readmissions* performance improvement project (PIP).

REGISTRATION

Providers can register for these teleconferences via email to CQI_Medicare@healthnet.com. Call-in information and meeting materials are emailed to registered participants prior to the teleconference.

Providers may access a calendar, materials and audio links after the teleconferences by visiting the Health Net provider website at provider.healthnet.com > *Working with Health Net* > *Quality* > *Provider Educational Teleconference Calendar* in the Provider Education section.

Providers may request continuing education hours and CME credits after attending the teleconference, and accessing materials and audio links online as directed on the website and during the teleconference.

[1] Provider-approved by the California Board of Registered Nursing, provider number CEP 13156, for one contact hour.

[2] This activity has been planned and implemented in accordance with the essential areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of St. Joseph's Hospital and Medical Center and Health Net. St. Joseph's Hospital and Medical Center is accredited by the ACCME to provide continuing medical education for physicians. St. Joseph's Hospital and Medical Center designates each session of this live activity/home study for a maximum of one *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

[3] Dates and times are subject to change.

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- ● Physicians
- ● Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

LINES OF BUSINESS:

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- ○ Advantage Platinum (PPO, POS)
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PROVIDER SERVICES

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PROVIDER*Update*

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CONTRACTUAL | MAY 23, 2014 | UPDATE 14-210 | 2 PAGES

Updated Behavioral Health Care Information in the Operations Manual

Health Net has updated behavioral health care services content in the Health Net Access provider operations manual located in the Provider Library on the Health Net provider website at provider.healthnet.com under *Operations Manuals > Benefits > Behavioral Health*. Updates affect behavioral health treatment, referral, coordination of care, and step therapy information.

BEHAVIORAL HEALTH TREATMENT

Primary care physicians (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 following Arizona Health Care Cost Containment System (AHCCCS) toolkits for best practices in treating these disorders:

- Adult ADHD
- Adult anxiety
- Adult depression
- Postpartum depression
- Child ADHD
- Child anxiety
- Child depression

The toolkits include assessment tools, scoring instructions and recommended medication lists, and are available on the Health Net provider website at provider.healthnet.com under *Working with Health Net > Quality > Behavioral Health for PCPs*.

PCP REFERRALS

PCPs are responsible for coordinating referrals for members requiring specialty or inpatient behavioral health services outside the scope of their practice, through the Regional Behavioral Health Authority (RBHA), or Tribal/Regional Behavioral Health Authority (T/RBHA) for members who are American Indians. For referrals, PCPs may use the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) Referral For Behavioral Health form located on the Health Net provider website at provider.healthnet.com under *Working with Health Net > Quality > Behavioral Health for PCPs*.

PCPs should establish medical records for members receiving behavioral health services through RBHA or T/RBHA when PCPs receive behavioral health information from RBHA or T/RBHA behavioral health providers, even if the members have not been seen at the PCPs' offices.

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fax (800) 937-6086

BEHAVIORAL HEALTH COORDINATION

PCPs should coordinate care with members' behavioral health providers as needed and provide all necessary medical records and documentation related to the diagnosis and care of the behavioral health condition that resulted in a referral. PCPs must respond to requests for information from the RBHA or T/RBHA for members who are American Indians, within 10 business days of receiving the request. Responses should include current diagnosis, medications, laboratory results, and last PCP, emergency room and hospital visits.

STEP THERAPY

PCPs must use step therapy as needed for treatment of ADHD, anxiety disorder, mild depression, and postpartum depression. Step therapy is required for medication not on the AHCCCS or DBHS preferred drug list. This includes the requirement that if the PCP receives documentation from RBHA or T/RBHA providers regarding completion of step therapy, the PCP continues prescribing the same brand-name medication and dosage of current medication, unless a change in medical condition is clearly evident.

Psychotropic medications are listed on the *Health Net Access Drug List*, available on the Health Net provider website at provider.healthnet.com.

ADDITIONAL INFORMATION

If you have questions regarding the information in this update, contact the Health Net Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

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CONTRACTUAL | MAY 13, 2014 | UPDATE 14-139 | 1 PAGE

Providers to Use AzAHP Practitioner or Organizational Data Forms

Effective immediately, physicians requesting participation in Health Net of Arizona's provider networks must complete the Arizona Association of Health Plans (AzAHP) Practitioner Data Form. Ancillary providers must use the AzAHP Organizational Data Form. The Health Net Provider Participation Request form is no longer accepted.

New requests to participate in the Health Net network or add new providers to an existing *Provider Participation Agreement (PPA)* require completion of the AzAHP forms, as applicable. Submit the form with required documentation to the appropriate Health Net Provider Network Management Department via fax or mail, as listed below.

Site	Mailing Address	Fax Number by County
TEMPE	Health Net of Arizona, Inc. Attn: Provider Network Management 1230 W. Washington Street, Suite 401 Tempe, AZ 85281	(602) 794-1803 Apache, Coconino, Gila, LaPaz, Maricopa, Mohave, Navaho, and Yavapai
TUCSON	Health Net of Arizona, Inc. Attn: Provider Network Management 5255 E. Williams Circle, Suite 4000 Tucson, AZ 85711	(520) 258-5172 Cochise, Graham, Greenlee, Pima, Pinal, Santa Cruz, and Yuma

ACCESSING THE FORMS

The AzAHP practitioner and organizational data forms are available pre- and post-log in on the Health Net provider website at provider.healthnet.com. Before logging in, the forms are located under *Health Net News & Resources > Complete a Network Participation Request Form*. After logging in, the forms are located under *Working With Health Net > Next Steps > Network Participation Request*. The AzAHP forms are also available electronically in the Provider Library, under *Forms > AzAHP Practitioner Data Form* or *AzAHP Organizational Data Form*. The forms are accompanied by a detailed list of guidelines to ensure proper use of each form by provider type.

Originally, Health Net used the AzAHP forms as required for the Health Net Access line of business and is expanding the use of these forms to include other lines of business.

ADDITIONAL INFORMATION

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

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- Physicians
- Medical Groups/IPAs
- ○ Hospitals
- Ancillary Providers

LINES OF BUSINESS:

- Advantage Platinum (HMO)
- Advantage Platinum (PPO, POS)
- Medicare Advantage (HMO)
- Health Net Access (AHCCCS)

PROVIDER SERVICES

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Health Net Access – (888) 788-4408
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CONTRACTUAL | APRIL 28, 2014 | UPDATE 14-165 | 3 PAGES

Medical Policies – 1st Quarter 2014

This provider update includes a listing of updated behavioral health clinical practice guidelines, preventive health guidelines, and new and updated Health Net medical policies approved by the Health Net National Medical Advisory Council (MAC) in the first quarter of 2014. For a complete description of new and updated medical policies, visit the Health Net provider website at provider.healthnet.com and select *Working with Health Net > Medical Policies*.

PURPOSE OF HEALTH NET MEDICAL POLICIES

Medical policies provide guidelines for determining medical necessity for specific procedures, equipment and services. All services must be medically necessary to be eligible for benefit coverage, unless otherwise defined in the member's benefits contract. The determination for coverage is also based on all of the terms of the individual member's benefits contract, including, but not limited to, eligibility at the time of service and description of covered benefits, limitations and exclusions. In some cases, legal or regulatory mandate requirements may be applicable and may prevail over medical policy. To the extent there are any conflicts between medical policy guidelines and applicable benefit contract language, the benefit contract language prevails. Medical policy is not intended to override the member *Evidence of Coverage* or the health insurance policy that defines the member's benefits, nor is it intended to provide medical advice or dictate to providers how to practice. If required, prior authorization must be obtained before services are rendered.

Behavioral Health Clinical Practice Guidelines

Policy	Change
MAJOR DEPRESSION GUIDELINES	No major changes; updated references
SUBSTANCE ABUSE DISORDER	No major changes; added background material and updated references

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center at provider.healthnet.com or as listed in the right-hand column.

THIS UPDATE APPLIES TO:

- Physicians
- Participating Physician Groups/ Medical Groups/IPAs
- Hospitals
- Ancillary Providers

STATE:

- Arizona
- California
- Oregon/Washington

LINES OF BUSINESS:

- All

ARIZONA

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Medicare Programs – (800) 929-9224
Cal MediConnect:
Los Angeles County – (855) 464-3571
San Diego County – (855) 464-3572
Medi-Cal – (800) 675-6110
CommunityCare Covered California – (888) 926-2164

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CommunityCare Cover Oregon – (888) 926-2480

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Preventive Health Guidelines

Topic	Summary
2014 ADULT FEMALE AND MALE PREVENTIVE HEALTH GUIDELINES	Guideline updates are based on recommendations of the United States Preventive Services Task Force (USPSTF) and other professional societies
2014 ADULT IMMUNIZATION SCHEDULE	This schedule is based on 2014 recommendations from the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP)
2014 CHILDHOOD AND ADOLESCENT IMMUNIZATION SCHEDULE AND CATCH-UP IMMUNIZATION SCHEDULE	This schedule is based on 2014 recommendation from the CDC's ACIP
2014 MATERNITY HEALTH GUIDELINES	Guideline updates are based on American Congress of Obstetricians and Gynecologists (ACOG) recommendations

New Policies

Medical Policy	Policy Statement
SURGICAL TREATMENT OF ESOPHAGEAL CANCER	This policy addresses operative approaches (open and laparoscopic) for esophageal cancer based on the location of the tumor and the available choices for a conduit (such as gastric, colon, jejunum)
VISCOSUPPLEMENTATION OF SHOULDER	This procedure is considered investigational due to the limited and inconsistent available data and lack of long-term outcomes of effectiveness

Updated Policies

Medical Policy	Change
CHEMOTHERAPY SENSITIVITY AND RESISTANCE ASSAYS	Added microculture kinetic (MICK) apoptosis assay as investigational based on National Comprehensive Cancer Network (NCCN) and the American Society of Clinical Oncology (ASCO) recommendations
COLONOSCOPY	The section on surveillance colonoscopy was revised for high-risk individuals based on recommendations from the NCCN
COMPARATIVE GENOMIC HYBRIDIZATION (CGH)	Added 2013 ACOG recommended indications for prenatal and postnatal testing
COMPUTER ASSISTED ORTHOPEDIC SURGERY	Added MAKOplasty® partial knee resurfacing and MAKOplasty total hip arthroplasty to the policy as investigational
CT SCANNING OR CHEST RADIOGRAPHS WITH OR WITHOUT COMPUTER-ASSISTED DETECTION (CAD) FOR LUNG CANCER SCREENING	Revised age criteria for lung cancer screening with low-dose computed tomography in individuals at high risk of developing lung cancer (when additional criteria are met) from ages 55-74 to ages 55-80 based on recommendation from USPSTF
GENDER REASSIGNMENT SURGERY	Added a section on hormone therapy based on World Professional Association for Transgender Health (WPATH) Version 7 recommendations

Updated Policies, continued

Medical Policy	Change
GENETIC TESTING FOR HEREDITARY NONPOLYPOSIS COLORECTAL CANCER (HNPCC)	Added NCCN recommendation for individuals with stage II colon cancer. Added microsatellite instability (MSI) testing and immunohistochemical (IHC) analysis (with or without BRAF mutation testing) of the tumor as medically necessary in either the universal or reflex testing approach to selective approach
INTENSITY-MODULATED RADIATION THERAPY (IMRT)	Removed daily image-guided radiation therapy (IGRT) with IMRT per the NCCN Guidelines for Prostate Cancer (version 1.2014)
MAGNETIC RESONANCE IMAGING (MRI) OF BREAST	Revised criteria wording to indicate that "First degree relative of BRCA carrier, but individual refuses BRCA testing" and "Lifetime risk 20% or greater, as defined by BRCAPRO or other models (e.g., Claus, BOADICEA, Tyrer-Cuzick) that are largely dependent on family history"
MAGNETIC RESONANCE SPECTROSCOPY (MRS) FOR VARIOUS DIAGNOSES	Added as medically necessary for individuals with prostate cancer when criteria noted in the policy are met, such as rising prostate-specific antigen (PSA) or positive digital rectal examination (DRE) after radiation therapy in the setting of a negative prostate biopsy
MOLECULAR TUMOR MARKERS FOR NON-SMALL CELL LUNG CANCER (NSCLC)	Added the ERCC1 biomarker as investigational for NSCLC when treatment with a platinum-based chemotherapy regimen is being considered
NATURAL ORIFICE TRANSLUMINAL ENDOSCOPIC SURGERY	Added peroral esophageal myotomy (POEM) as investigational
PHARMOCOGENETIC TESTING	Added Food and Drug Administration (FDA)-approved test for BRAF V600E and V600K mutations (THxD BRAF test) as medically necessary for unresectable or metatastic melanoma for individuals being considered for treatment with either dabrafenib or trametinib. Added MGMT (O-6-methylguanine-DNA methyltransferase) gene methylation assay as medically necessary for predicting response to chemotherapeutic agent temozolomide (Temodar®) in individuals with glioblastoma, ages 70 or younger, with a Karnofsky performance status greater than 70
PHYSICAL AND OCCUPATIONAL THERAPY	Added descriptive information under the Occupational Therapy section and updated sensory integration therapy and habilitative services
STEREOTACTIC RADIOSURGERY	Made revisions to policy statement based on various NCCN recommendations
TERBUTALINE PUMP	Removed "in the home" from the policy title. Added a note that the FDA posted warnings that injectable terbutaline may be used only in an inpatient, monitored setting and should not be used for longer than 48-72 hours. Terbutaline should not be used in an outpatient setting or in the home
TUMOR MARKERS FOR CANCER	Added Molecular Intelligence™, a group of molecular biomarker tests provided by Caris Life Sciences®, based upon a previous test, Target Now™ molecular profiling, as investigational
VARICOSE VEINS – SURGICAL INTERVENTIONS	Added the ClariVein® infusion catheter, proposed as an endovenous mechanochemical ablation for peripheral venous reflux, as investigational

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Fluoride Varnish Application Reimbursement and Training

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits include appropriate oral health screening to identify oral pathology, including tooth decay and oral lesions. Fluoride varnish may be applied during routine EPSDT visits conducted by a physician, physician assistant (PA) or nurse practitioner (NP).

The use of a prophylaxis paste containing fluoride or fluoride mouth rinses do not meet the AHCCCS standard for fluoride treatment. Application of fluoride varnish does not take the place of an oral health visit with a dentist.

BILLING

Effective April 1, 2014, physicians, PAs and NPs who have completed the Arizona Health Care Cost Containment System (AHCCCS)-recommended training may be reimbursed for fluoride varnish applications that are completed at EPSDT visits for members ages six months and older with at least one tooth eruption. Providers may be reimbursed for additional applications occurring every six months thereafter during EPSDT visits, up to a member's second birthday, in accordance with AHCCCS-approved fee schedules.

Application of fluoride varnish must be billed separately from the EPSDT visit using procedure code D1206 and ICD-9 diagnosis code V07.31.

TRAINING

The AHCCCS-required training – Course 6: Caries Risk Assessment, Fluoride Varnish and Counseling – is available on the American Academy of Pediatrics (AAP) website at http://elearning.talariainc.com/buildcontent.aspx?tut=584&pagekey=64563&cbreceipt=0. Select *Next* to launch the course.

Upon completion of the required training, providers must pass the post-test in order to bill Health Net for the application of fluoride varnish. Continuing education credits are provided to those completing the course and passing the test.

Providers are required to submit a copy of their completion certificate to the Health Net Access Quality Improvement (QI) Department via fax at (866) 524-5734. This certificate is used during the credentialing process to verify completion of the training and is necessary for reimbursement.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- ● Physicians
- ● Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

LINES OF BUSINESS:

- ○ Advantage Platinum (HMO)
- ○ Advantage Platinum (PPO, POS)
- ○ Medicare Advantage (HMO)
- ● Health Net Access (AHCCCS)

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New Regional Behavioral Health Authority for Maricopa County

Effective April 1, 2014, Mercy Maricopa Integrated Care (MMIC) is the new Regional Behavioral Health Authority (RBHA) for Maricopa County replacing Magellan of Arizona. Health Net Access members with serious mental illness (SMI) are being disenrolled from Health Net and enrolled in MMIC on April 1, 2014. MMIC then becomes the acute and behavioral health plan for members with SMI.

Health Net Access members without SMI, but receiving general mental health services, remain assigned to Health Net for acute care services. MMIC becomes the behavioral health provider for these members.

Health Net's goal is to ensure that members continue to receive the services they need and are able to complete appointments with providers as scheduled. During the transition period, if an SMI member's provider is non-contracting with MMIC, the member is allowed to continue to see the non-contracting provider for up to 180 days. This allows for a smooth transition for the member with minimal interruption until the member can be placed with a contracting provider.

The behavioral health scope of practice for primary care physicians (PCPs) remains the same, and continues to include treatment of attention deficit hyperactivity disorder (ADHD), anxiety, mild depression, and postpartum depression. The RBHA referral process, behavioral health services and the RBHA customer service number, (800) 564-5465, are not changing.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

Online Medical Policies

Health Net develops evidence-based medical policies through critical appraisal of current published peer-reviewed medical literature to support providers in determining medical necessity for specific procedures, equipment and services. A complete description of new and updated medical policies is located on the Health Net provider website at provider.healthnet.com > *Working with Health Net* > *Clinical* > *Medical Policies*.

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- ● Physicians
- ○ Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

LINES OF BUSINESS:

- ○ Advantage Platinum (HMO)
- ○ Advantage Platinum (PPO, POS)
- ○ Medicare Advantage (HMO)
- ● Health Net Access (AHCCCS)

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CONTRACTUAL | MARCH 3, 2014 | UPDATE 14-093 | 1 PAGE

Outpatient Physical Therapy Benefit Change for Adult Members

Effective March 1, 2014, Health Net Access covers 15 outpatient physical therapy visits per benefit year for members to maintain a level of function or help achieve a level of function when medically necessary. This is an additional benefit for Health Net Access members ages 21 and older.

Previously, Health Net Access adult members were eligible to receive 15 outpatient physical therapy visits to restore a level of function. Now, Health Net Access adult members receive both 15 outpatient physical therapy visits to restore a level of function and 15 outpatient physical therapy visits to maintain or help achieve a level of function when medically necessary. The outpatient physical therapy visits are covered during each benefit year.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

Online Medical Policies

Health Net develops evidence-based medical policies through critical appraisal of current published peer-reviewed medical literature to support providers in determining medical necessity for specific procedures, equipment and services. A complete description of new and updated medical policies is located on the Health Net provider website at provider.healthnet.com > *Working with Health Net* > *Clinical* > *Medical Policies*.

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- ● Physicians
- ○ Medical Groups/IPAs
- ○ Hospitals
- ● Ancillary Providers

LINES OF BUSINESS:

- ○ Advantage Platinum (HMO)
- ○ Advantage Platinum (PPO, POS)
- ○ Medicare Advantage (HMO)
- ● Health Net Access (AHCCCS)

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CONTRACTUAL | FEBRUARY 7, 2014 | UPDATE 14-048 | 3 PAGES

Medical Policies – 4th Quarter 2013

This provider update includes a listing of updated behavioral health clinical practice guidelines and new and updated Health Net medical policies approved by the Health Net National Medical Advisory Council (MAC) in the fourth quarter of 2013. For a complete description of new and updated medical policies, visit the Health Net provider website at provider.healthnet.com and select *Working with Health Net > Medical Policies*.

PURPOSE OF HEALTH NET MEDICAL POLICIES

Medical policies provide guidelines for determining medical necessity for specific procedures, equipment and services. All services must be medically necessary to be eligible for benefit coverage, unless otherwise defined in the member's benefits contract. The determination for coverage is also based on all of the terms of the individual member's benefits contract, including, but not limited to, eligibility at the time of service and description of covered benefits, limitations and exclusions. In some cases, legal or regulatory mandate requirements may be applicable and may prevail over medical policy. To the extent there are any conflicts between medical policy guidelines and applicable benefit contract language, the benefit contract language prevails. Medical policy is not intended to override the member *Evidence of Coverage* or the health insurance policy that defines the member's benefits, nor is it intended to provide medical advice or dictate to providers how to practice. If required, prior authorization must be obtained before services are rendered.

Behavioral Health Clinical Practice Guidelines

Policy	Change
ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)	Minor revisions. Added new references
BUPRENORPHINE TREATMENT	Minor revisions. Added warning to administer and store safely. Added new references

New Policies

Medical Policy	Policy Statement
BREAST TOMOSYNTHESIS (3-D MAMMOGRAPHY)	Digital breast tomosynthesis (DBT) is considered investigational for all indications as there is insufficient evidence in medical literature to recommend this technology for routine screening or diagnosis

THIS UPDATE APPLIES TO:

- Physicians
- Participating Physician Groups/ Medical Groups/IPAs
- Hospitals
- Ancillary Providers

STATE:

- Arizona
- California
- Oregon/Washington

LINES OF BUSINESS:

- All

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New Policies, continued

Medical Policy	Policy Statement
QUANTITATIVE ELECTROENCEPHALOGRAPHY	Considered medically necessary as an adjunct to traditional electroencephalogram (EEG) for specific conditions when the EEG is inconclusive, and other American Academy of Neurology (AAN) guidelines are met
TRANSCATHETER PLACEMENT OF INTRACRANIAL STENT	Considered medically necessary for a cerebral aneurysm when surgical treatment is not appropriate or attempted surgery was unsuccessful; and standard endovascular techniques are inadequate to achieve complete isolation of the aneurysm because of anatomic considerations, which include, but are not limited to, wide-neck aneurysm (4 mm or greater); or sack- or dome-to-neck ratio less than 2:1. Refer to policy for specific criteria

Updated Policies

Medical Policy	Change
ACUPUNCTURE	Added acupuncture for chronic obstructive pulmonary disease (COPD) as investigational since there is a paucity of long-term, randomized controlled trials (RCTs) to support this indication
ARTIFICIAL INTERVERTEBRAL DISC	Although the U.S. Food and Drug Administration (FDA) approved the Mobi-C® cervical disc prosthesis to replace two adjacent cervical discs from C3-C7, there remains a paucity of peer-reviewed literature to support the use of this device for two level indications. This continues to be considered investigational at more than one level
CARDIAC DEFIBRILLATOR, IMPLANTABLE	Changed policy name from Cardiac Defibrillator (AICD), Automatic Implantable to Implantable Cardiac Defibrillator. Revised policy to consider subcutaneous implantable cardioverter-defibrillator (S-ICD) a medically reasonable option for individuals who meet criteria for a standard transvenous implantable cardioverter-defibrillator system for primary or secondary prevention of sudden cardiac death
CARDIAC RISK ASSESSMENT – LABORATORY TESTS	Corus® CAD continues to be considered investigational because there is insufficient evidence in the peer-reviewed medical literature to support this whole blood gene expression test in predicting coronary artery disease (CAD). May be covered for Medicare members as indicated by Medicare coverage determinations
COCCYGECTOMY AND TREATMENTS FOR COCCYDYNIA	Ganglion impar coccygeal injections were added as medically necessary for chronic coccydynia when other conservative measures (such as physical therapy, treatment with oral analgesics, or epidural steroid injections) have not alleviated pain and the individual is not a surgical candidate
CONTINUOUS GLUCOSE MONITORING	Added artificial pancreas (MiniMed® 530G system) as investigational, revised the hemoglobin A1C (HgbA1c) value to seven percent or greater, and removed the requirement for 30 days of documentation
FIBROSPECT	Added ActiTest, alcoholic steatorrheic hepatitis (ASH) and non-alcoholic steatorrheic hepatitis (NASH) FibroSure serum marker tests and FibroScan® (transient elastography) as investigational

Updated Policies, continued

Medical Policy	Change
GENETIC TESTING INDICATIONS	Revised policy statement to address testing panels, including, but not limited to, multiple genes or multiple conditions. In cases where a tiered approach or method is clinically available, testing is covered only for the number of genes or tests deemed medically necessary to establish a diagnosis
HEART TRANSPLANT (ADULT AND ADOLESCENT)	HIV was removed as an absolute contraindication for heart transplants
HEART TRANSPLANTATION REJECTION MONITORING (ALLOMAP® GENE-EXPRESSION TESTING, HEARTSBREATH™ TEST)	Added that Allomap may be considered medically necessary in lieu of endomyocardial biopsy in low-risk patients to determine rejection according to the interval specified in the policy
HYPERHIDROSIS TREATMENTS	Added laser, microwave and radiofrequency ablation procedures as investigational
LEFT ATRIAL APPENDAGE DEVICES (FORMERLY THE WATCHMAN™ PROCEDURE)	Added the Lariat® system, Cardioblate® closure device, Amplatzer® atrial septal closure device, and AtriClip® system, to the Watchman procedure, as investigational
MATERNIT21™ PLUS, HARMONY™, VERFI®, OR PANORAMA™ TESTING	Added Maternit21 PLUS and Panorama tests, cell-free DNA screening tests, to the policy statement as medically necessary. MaterniT21 PLUS takes the place of MaterniT21. In addition to detecting fetal aneuploidies for trisomy 21 (Down syndrome), MaterniT21™ Plus now also detects fetal aneuploidies for trisomy 18 (Edwards syndrome and trisomy 13 (Patau syndrome). Policy title revised to include all four tests
NEOVASCULAR WET MACULAR DEGENERATION	Added radiation treatment modalities as investigational
OBSTRUCTIVE SLEEP APNEA, DIAGNOSIS AND TREATMENT	Revised criteria to follow MedSolutions criteria
PROTON BEAM	Revised to consider routine treatment of localized prostate cancer not medically necessary as noted by the National Comprehensive Cancer Network (NCCN) Guidelines for Prostate Cancer V4.2013
TRANSCATHETER ARTERIAL CHEMOEMBOLIZATION (TACE) OF LIVER CANCER	Added Embozene® Microspheres, in conjunction with transarterial bland embolization, to decrease the blood supply of unresectable, intermediate and advanced-stage hepatocellular carcinoma to investigational section of policy. Added TACE as bridge to transplant/downstaging therapy to medically necessary section. Removed references to size of tumor from the medically necessary criteria in policy statement
WOUND CARE	Added MatriStem® Wound Matrix as investigational
URINARY INCONTINENCE DEVICE AND TREATMENTS	Added tension-free vaginal tape (TVT) as a medically necessary procedure in females with stress urinary incontinence who meet specific criteria noted in policy statement

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center at provider.healthnet.com or as listed in the right-hand column on page 1.

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NEWS & ANNOUNCEMENTS | DECEMBER 13, 2013 | UPDATE 13-541 | 1 PAGE

Discontinuation of Supplemental Paper Remittance Advice

Effective December 15, 2013, Health Net is discontinuing supplemental paper remittance advices (RAs) for providers who previously registered for electronic RA (ERA). This process is in accordance with the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE), and Electronic Funds Transfer (EFT) and ERA Operating Rules.

Providers who would like to continue receiving both paper and electronic RAs should contact Health Net Electronic Data Interchange (EDI) via email at edi.support@healthnet.com or by telephone at (800) 977-3568.

ERA REGISTRATION

Health Net offers ERA and EFT to help reduce the following:

- Administrative work – convenient record-keeping with no more paper handling
- Claims-related problems – streamlined claims processing improves provider satisfaction
- Check-processing expenses – direct deposit saves time and money with fewer processing fees

To register for ERA or EFT, visit the Health Net provider website at provider.healthnet.com > *Working with Health Net* > *EDI*. Newly registering providers receive the electronic RAs as well as supplemental paper RAs for 31 days, after which the supplemental paper RAs are discontinued.

ADDITIONAL INFORMATION

For additional information on the CAQH CORE, EFT and ERA Operating Rules mandate, visit the CAQH website at www.caqh.org/ORMandate_EFT.php#Rules.

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center as listed in the right-hand column.

Provider-Relevant Articles Online

Access informative Online News articles today by logging in to provider.healthnet.com. Select the rotating graphic to read or print the articles of interest. Health Net posts new articles each week that cover a variety of topics, such as health plan updates, administrative procedure reminders, quality improvement tips, and health care initiatives.

THIS UPDATE APPLIES TO:

- Physicians
- Participating Physician Groups/ Medical Groups/IPAs
- Hospitals
- Ancillary Providers

STATE:

- Arizona
- California
- Oregon/Washington

LINES OF BUSINESS:

- All

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CONTRACTUAL | DECEMBER 13, 2013 | UPDATE 13-537 | 1 PAGE

OptumInsight™ Verifies Provider Credentials for Health Net Access

The Arizona Association of Health Plans (AzAHP) contracts with OptumInsight™, also known as Optum, to provide primary source verification (PSV) of practitioner and facility credentials for health plans participating in the Arizona Health Care Cost Containment System (AHCCCS) program. Effective immediately, Optum performs PSV services on Health Net's behalf for practitioners and facilities credentialing or recredentialing for the Health Net Access line of business. Health Net authorizes Optum to collect and verify provider credentials; all other credentialing processes remain the same for participating practitioners, facilities and their offices.

APPLICATION PROCESS

As part of the PSV process, AzAHP agreed to use the Council for Affordable Quality Healthcare (CAQH) Universal Provider Datasource® for all practitioner credentialing applications. AzAHP uses a paper credentialing application for all facilities.

Beginning in November 2013, Optum sends correspondence to select practitioners and facilities requesting completion of a CAQH or organizational provider credentialing application. It is critical that Health Net Access participating practitioners and facilities complete or update the credentialing application as requested by Optum. Optum staff may contact the provider's office directly when additional information is needed to complete an application.

CONFIDENTIALITY REQUIREMENTS

Optum has entered into a Primary Source Verification Credentialing Services Agreement with AzAHP, which contains a Joinder Agreement that Health Net has signed as a new AzAHP participant, along with a Confidentiality and Nondisclosure Agreement. As such, Optum is bound by applicable federal and state privacy and confidentiality requirements in conducting this activity on Health Net's behalf.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

Provider-Relevant Articles Online

Access informative Online News articles today by logging in to provider.healthnet.com. Select the rotating graphic to read or print the articles of interest. Health Net posts new articles each week that cover a variety of topics, such as health plan updates, administrative procedure reminders, quality improvement tips, and health care initiatives.

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- ● Physicians
- ○ Medical Groups/IPAs
- ● Hospitals
- ● Ancillary Providers

LINES OF BUSINESS:

- ○ Advantage Platinum (HMO)
- ○ Advantage Platinum (PPO, POS)
- ○ Medicare Advantage (HMO)
- ● Health Net Access (AHCCCS)

PROVIDER SERVICES

az_internetproviderinquiries@healthnet.com
(888) 788-4408
www.healthnet.com

NATIONAL PROVIDER COMMUNICATIONS

provider.communications@healthnet.com
fax (800) 937-6086

PROVIDER*Update*

Health Net®

CONTRACTUAL | DECEMBER 12, 2013 | UPDATE 13-534 | 2 PAGES

Interpreter Services and Cultural Training

Health Net offers participating physicians, medical groups, ancillary providers, and members 24-hour access to telephonic interpreter services. Additionally, Health Net offers in-person interpreter services, as well as sign language assistance, during business hours at no cost. These services feature the following:

- Qualified interpreters trained on health care terminology and a wide range of interpreting protocols and ethics
- Support to address common communication challenges across cultures

This communication describes Health Net interpreter services and lists access information.

INTERPRETER SERVICES

Information regarding telephonic interpreter services is available by contacting the Provider Services Center at (888) 788-4408, 24 hours a day, seven days a week. To have an in-person interpreter or sign-language interpreter present at your site, providers must schedule it no less than three to five business days prior to the member's appointment. In-person interpreters are available between 7:00 a.m. and 6:00 p.m., Monday through Friday.

When calling, providers must have the following information available:

- Member name
- Member Health Net identification (ID) number
- Appointment date and time, if necessary

CULTURAL AND LINGUISTIC APPROPRIATENESS

Health Net provides the following to comply with mandated cultural and linguistic appropriateness standards:

- Oral language services that include answering questions and providing assistance in any non-English language
- Upon request, Spanish translation of vital documents that provide information on eligibility and how to participate in the plan
- A statement indicating how to access language services in any applicable non-English language

PROVIDER RESPONSIBILITIES

Participating providers may use Health Net's interpreter services to provide interpreters to members who require or request them. Participating providers must ensure that language services meet the established requirements as follows:

- Ensure that limited-English proficient (LEP) members are not subject to unreasonable delays in the delivery of services

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- ● Physicians
- ● Medical Groups/IPAs
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- ● Ancillary Providers

LINES OF BUSINESS:

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- Not require or encourage members to use family members or friends as interpreters. Health Net strongly discourages the use of minors as interpreters, unless used in an emergency situation
- Provide interpreter services at no cost to members
- Extend same participation opportunities in programs and activities to all members regardless of their language preferences
- Provide services to LEP members that are as effective as those provided to others
- Record the language needs of each member, as well as the member's request or refusal of interpreter services, in his or her medical record
- Advise members that they may file grievances with Health Net if their language needs are not meet

PROVIDERS DELEGATED FOR UTILIZATION MANAGEMENT ONLY

In addition to the above, providers delegated for utilization management (UM) must comply with the following:

- Translation services – Provide Health Net with the documents sent to members, upon request, in a timely manner. If a Health Net member requests translation of an English document that was produced by an ancillary provider on Health Net's behalf, the provider must refer the member to the Health Net Customer Contact Center (CCC) telephone number listed on the member's ID card. When Health Net's CCC receives the member's request, Health Net contacts the provider requesting a copy of the specific English document for translation. The provider must submit the document within 48 hours of Health Net's request
- Notice of Language Assistance (NOLA) – Include Health Net-specific NOLA, which advises members that they can receive support in their preferred language, with vital documents distributed to Health Net members (for example, UM denial and delay notices, and claims notices that require member action). A sample notice is available online at provider.healthnet.com under *Working with Health Net > Contractual > Policy Library > Go to the Provider Library > Select a Provider Library > Forms > Notice on the Availability of Language Assistance*

CULTURAL COMPETENCY TRAINING

All participating providers are required to take cultural competency training. The United States Department of Health and Human Services' Office of Minority Health (OMH) offers a computer-based training (CBT) program on cultural competency for health care providers. This program was developed to furnish providers with competencies enabling them to better treat the United States' increasingly diverse population. For more information, refer to the OMH Think Cultural Health website at https://cccm.thinkculturalhealth.hhs.gov. Health Net does not sponsor or maintain the OMH CBT or website.

ADDITIONAL INFORMATION

Providers who would like information on cross-cultural communication, health literacy or accessing interpreter services may contact Health Net's Cultural and Linguistic Services Department by email at Cultural.and.Linguistic.Services@healthnet.com or by telephone at (800) 977-6750.

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

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PROVIDER*Update*

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CONTRACTUAL | DECEMBER 11, 2013 | UPDATE 13-538 | 1 PAGE

Health Net Access Provider Claim Dispute Form Updated

Effective December 11, 2013, the Health Net Access Provider Claim Dispute form has been updated and is available on Health Net's provider website at provider.healthnet.com in the Provider Library under *Forms > Health Net Access Provider Claim Dispute Form.* At the request of the Arizona Health Care Cost Containment System (AHCCCS), references to *appeals* have been replaced with *disputes.*

Providers should complete and submit this form when:

- Requesting reconsideration of a claim that has been denied or adjusted
- Challenging a request for reimbursement for an overpayment of a claim
- Seeking resolution of a billing determination or other contractual dispute

ADDITIONAL INFORMATION

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- ● Physicians
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- ● Hospitals
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LINES OF BUSINESS:

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PROVIDER*Update*

CONTRACTUAL | DECEMBER 6, 2013 | UPDATE 13-521 | 2 PAGES

Monitoring Medicaid Provider Exclusions

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. This communication provides the names of each federal exclusion list, governing regulations and AHCCCS guidance, including links to publically available 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.

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- Physicians
- Medical Groups/IPAs
- Hospitals
- Ancillary Providers

LINES OF BUSINESS:

- ○ Advantage Platinum (HMO)
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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. Providers contracting with Health Net must have a documented process in place to ensure compliance with these guidelines, and notify enrollees who obtain services from excluded parties and make claims payments as allowed under these exceptions. This documentation is subject to audit upon request from Health Net or CMS.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

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PROVIDER*Update*

CONTRACTUAL | DECEMBER 5, 2013 | UPDATE 13-496 | 1 PAGE

Health Net®

EPSDT Tracking Form Requirements

All Health Net Access participating providers who provide preventive health care services to Health Net Access members under age 21 must complete the age-appropriate Arizona Health Care Cost Containment System (AHCCCS) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) tracking form. The EPSDT tracking form is used to document preventive services for Medicaid members and monitor compliance with EPSDT and dental periodicity schedules.

Providers must file a copy of the EPSDT tracking form in the member's medical record and submit a copy of the completed form to the Health Net Encounter Department via fax to (916) 935-4476 or by mail at:

Health Net Encounter Department
PO Box 419071
Rancho Cordova, CA 95741

The tracking forms and completion instructions are available on the AHCCCS website at www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixB.pdf and on the Health Net provider website at provider.healthnet.com in the Provider Library under *Forms > EPSDT Tracking Forms.*

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

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- ○ Hospitals
- ○ Ancillary Providers

LINES OF BUSINESS:

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CONTRACTUAL | NOVEMBER 26, 2013 | UPDATE 13-495 | 1 PAGE

Behavioral Health Referral Process

Health Net Access primary care physicians (PCPs) provide outpatient behavioral health services within the scope of their practice, and coordinate referrals for members requiring specialty or inpatient behavioral health services through the Regional Behavioral Health Authority (RBHA) system. The RBHA for Health Net Access members is Magellan Health Services of Arizona. This update provides the behavioral health referral process PCPs must follow.

REFERRALS

PCPs must refer members for specialty or inpatient behavioral health services via the behavioral health referral form. PCPs may obtain the form as follows:

- Email a request to maricoparbhahpreferrals@magellanhealth.com
- Fax a request to (866) 892-5023
- Download the form from the Magellan Health Services of Arizona website at www.magellanofaz.com > *For Providers* > *Provider Forms* > *ADHS/DBHS Referral to Behavioral Health Services*

The PCP must complete page one of the referral form; there is no need to include medical records. Magellan completes page two and returns the form to the PCP upon completion of the referral process.

Submit the completed referral form via secure fax to the dedicated behavioral health referral line at (866) 892-5023 or via email to maricoparbhahpreferrals@magellanhealth.com.

PSYCHIATRIC CONSULTATIONS

General

Health Net PCPs with general diagnostic and treatment questions may contact RBHA behavioral health medical practitioners at (800) 564-5465.

One-Time Face-to-Face

A PCP may also request that member has a one-time, face-to-face psychiatric evaluation with the RBHA behavioral health provider for treatment, ongoing behavioral health care or medication management provided by the PCP. The PCP must complete the behavioral health referral form to request the member's face-to-face psychiatric consultation, and submit the form to the dedicated behavioral health referral line via secure fax at (866) 892-5023 or via email to maricoparbhahpreferrals@magellanhealth.com.

ADDITIONAL INFORMATION

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THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- ● Primary Care Physicians
- ○ Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

LINES OF BUSINESS:

- ○ Advantage Platinum (HMO)
- ○ Advantage Platinum (PPO, POS)
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Health Net, Inc.

PROVIDER*Update*

CONTRACTUAL | NOVEMBER 21, 2013 | UPDATE 13-490 | 3 PAGES

Medical Policies – 3rd Quarter 2013

This provider update includes a listing of new and updated Health Net medical policies approved by the Health Net National Medical Advisory Council (MAC) in the third quarter of 2013. For a complete description of new and updated medical policies, visit the Health Net provider website at provider.healthnet.com and select *Working with Health Net > Medical Policies*.

PURPOSE OF HEALTH NET MEDICAL POLICIES

Medical policies provide guidelines for determining medical necessity for specific procedures, equipment and services. All services must be medically necessary to be eligible for benefit coverage, unless otherwise defined in the member's benefits contract. The determination for coverage is also based on all of the terms of the individual member's benefits contract, including, but not limited to, eligibility at the time of service and description of covered benefits, limitations and exclusions. In some cases, legal or regulatory mandate requirements may be applicable and may prevail over medical policy. To the extent there are any conflicts between medical policy guidelines and applicable benefit contract language, the benefit contract language prevails. Medical policy is not intended to override the member *Evidence of Coverage* or the health insurance policy that defines the member's benefits, nor is it intended to provide medical advice or dictate to providers how to practice. If required, prior authorization must be obtained before services are rendered.

New Policies

Medical Policy	Policy Statement
CIRCUMCISION	Applicable to specific Medicaid plans to indicate that this procedure is covered only when medically indicated
ELECTRIC TUMOR TREATMENT FIELDS (NOVO TTF™–100A SYSTEM)	Considered medically necessary for treatment of adult patients (ages 22 and older) with histologically confirmed glioblastoma multiforme (GBM), following histologically or radiologically confirmed recurrence in the supratentorial region of the brain after receiving chemotherapy. The device is intended for use as a monotherapy and as an alternative to standard medical therapy for GBM after surgical and radiation options have been exhausted

THIS UPDATE APPLIES TO:

- Physicians
- Participating Physician Groups/ Medical Groups/IPAs
- Hospitals
- Ancillary Providers

STATE:

- Arizona
- California
- Oregon/Washington

LINES OF BUSINESS:

- All

ARIZONA

az_internetproviderinquiries@healthnet.com
HMO, PPO, POS, Medicare Advantage – (800) 289-2818
Health Net Access – (888) 788-4408

CALIFORNIA

provider_services@healthnet.com
HMO/POS, PPO & EPO – (800) 641-7761
Healthy Families Program – (888) 231-9473
Medicare Programs – (800) 929-9224
Medi-Cal – (800) 675-6110

OREGON/WASHINGTON

EPO, POS, PPO, & CommunityCare – (888) 802-7001
Medicare Advantage HMO/PPO – (888) 445-8913

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New Policies, continued

Medical Policy	Policy Statement
PNEUMATIC COMPRESSION DEVICE	Indicates that it may be considered medically necessary post-surgery with contraindications to anticoagulants, known bleeding disorders, or inability to ambulate; or as an adjunct to pharmacologic prophylaxis with previous venous thromboembolism; or as an alternative to low molecular weight heparin post hip surgery
TUMOR MARKERS FOR CANCER	Provides the medical necessity criteria for various tumor markers for the diagnosis and/or management of cancer

Updated Policies

Medical Policy	Change
ANCA FOR CROHNS DISEASE AND ULCERATIVE COLITIS	Added several assays (gASCA, anti-OmpC, ACCA, ALCA) to the policy statement as medically necessary when criteria are met
BONE ANCHORED HEARING AIDS (BAHA)	Added contraindication to BAHA, such as artificial heart valves, rheumatic heart valves and congenitally abnormal heart valves
CELIAC DISEASE LABORATORY TESTING	Removed testing of anti-gliadin antibodies and anti-reticulin antibodies from the policy statement as these tests are no longer recommended. Added 2013 recommendations from the American College of Gastroenterology (ACG) guidelines on celiac disease
GENETIC TESTING FAMILIAL ADENOMATOUS POLYPOSIS (FAP)	Revised criteria regarding confirmation of the diagnosis of attenuated familial adenomatous polyposis (AFAP) from greater than 20 to greater than 10 cumulative colorectal adenomas. Added National Comprehensive Cancer Network (NCCN) recommendation for testing of adenomatous polyposis coli (APC) and/or mutY homolog (MUTYH) to differentiate between FAP/AFAP from MUTYH-associated polyposis (MAP) and colonic polyposis of unknown etiology
GENETIC TESTING FOR BRCA1 AND BRCA2	Based on NCCN guidelines version 4.2013, revised the criteria under the *Women with a personal history of breast cancer* section to include: • Diagnosed under age 50 with more than one close blood relative with breast cancer at any age or with a limited family history • Diagnosed at any age with more than one close blood relative with epithelial ovarian cancer
GENETIC TESTING FOR MULTIPLE ENDOCRINE NEOPLASIA TYPE 1	Revised policy statement to include genetic testing for multiple endocrine neoplasia type 1 (MEN1) in at-risk relative or individual with a known germline MEN1 mutation as medically necessary
HIV ANTIRETROVIRAL DRUG RESISTANCE TESTING	Added as medically necessary for testing of adults and adolescents, "In persons failing integrase strand transfer inhibitor (INSTI)-based regimens (such as, raltegravir), a genetic assay for INSTI resistance should be performed to determine whether to include a drug from this class in subsequent regimens"

Updated Policies, continued

Medical Policy	Change
INTRAPERITONEAL CHEMOTHERAPY FOR OVARIAN CANCER	Added as a medically necessary treatment option for women with optimally debulked stage II ovarian cancer who have undergone optimal surgical cytoreduction with no or minimal residual disease (2013 NCCN recommendation)
NERVE CONDUCTION STUDIES	Added radiculopathy, polyneuropathy, plexopathy, and myopathy to the policy statement as medically necessary
RADIOFREQUENCY ABLATION OF LUNG TUMORS	Added as medically necessary for node negative non-small cell lung cancer (NSCLC), isolated peripheral lesions less than 3 cm; or for palliation with stage IIB NSCLC (2013 NCCN recommendation)
TRANSANAL ENDOSCOPIC MICROSURGERY FOR RECTAL CANCER	Revised policy statement to note that low risk T1 tumors should occupy less than 30 percent of rectal wall circumference with clear margins greater than 3 mm, within 8 cm of anal verge based on 2013 NCCN recommendation
TRANSCATHETER ARTERIAL CHEMOEMBOLIZATION FOR LIVER CANCER	Clarified indications and relative contraindications in the policy statement. Added transcatheter arterial chemoembolization (TACE) as bridge to transplant/downstaging therapy as investigational based on NCCN recommendations
VIDEO EEG	Added indication for seizure monitoring of child as medically necessary to develop or modify treatment or to establish diagnosis of epilepsy in young children with clinical symptoms consistent with epilepsy, but who present with diagnostic difficulties after clinical assessment and standard electroencephalogram (EEG)
WIRELESS CAPSULE ENDOSCOPY (WCE)	Added a medically necessary indication for surveillance of small intestinal tumors in individuals with Lynch syndrome, Peutz-Jeghers syndrome and other polyposis syndromes affecting the small bowel

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center at provider.healthnet.com or as listed in the right-hand column on page 1.

PROVIDER*Update*

REGULATORY | NOVEMBER 18, 2013 | UPDATE 13-424 | 2 PAGES

Member Direct Payment Notification Required

Effective December 31, 2013, in accordance with Arizona House Bill (HB) 2045 (February 22, 2013), before a health care provider who is contracting as a network provider for a health care system, such as Health Net, accepts direct payment from a member or employer group, the provider must obtain a signed, direct payment notification from the member or employer. Health Net offers a template for providers to use in creating forms to meet this requirement.

DIRECT PAYMENT NOTIFICATION TEMPLATE

Health Net's Member Direct Payment Notification Template: Facility or Provider is attached for providers and is also available on the Health Net provider website at provider.healthnet.com, under *Working With Health Net > Contractual > Policy Library > Go To The Provider Library > Forms*.

The Member Direct Payment Notification template instructs members whose providers or facilities are contracting with Health Net to read and acknowledge the following guidelines before making any agreement to pay health care providers or facilities directly for covered services:

1. You may not be required to pay the health care provider or facility directly for the services covered by your plan, except for cost-share amounts that you are obligated to pay under your plan, such as copayments, coinsurance and deductible amounts.
2. Your health care provider's agreement with Health Net may prevent the provider from billing you for the difference between the facility or provider's billed charges and the amount allowed by your health plan for covered services.
3. If you pay the provider or facility directly for a health care service, the provider or facility is not responsible for submitting claim documentation to Health Net. Before paying your claim, your health plan may require you to provide information and submit documentation necessary to determine whether the services are covered under your plan.
4. If you do not pay the provider or facility directly for a health care service, your provider or facility may be responsible for submitting claim documentation to your health plan for the health care service.

ADDITIONAL INFORMATION

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- Ancillary Providers

LINES OF BUSINESS:

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- Medicare Advantage (HMO)
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www.healthnet.com

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Health Net

Health Net Member Direct Payment Notification Template: Provider *or* Facility

Instructions for the provider or facility: Use the following text and choose Facility *or* Provider from this template to create a form. Health Net members must read and acknowledge the following guidelines before making any agreement to pay you, a participating Health Net provider, or a facility directly for covered services.

The Arizona state constitution permits you to pay a health care <facility/provider> directly for health care services. Before you make any agreement to do so, please read the following important information.

If you are a Health Net member and your health care <facility/provider> is contracting with Health Net, the following guidelines apply:

1. You may not be required to pay the health care <facility/provider> directly for the services covered by your plan, except for cost-share amounts that you are obligated to pay under your plan, such as copayments, coinsurance and deductible amounts.

2. Your provider's agreement with Health Net may prevent the health care <facility/provider> from billing you for the difference between the <facility's/provider's> billed charges and the amount allowed by your health plan for covered services.

3. If you pay directly for a health care service, your health care <facility/provider> is not responsible for submitting claim documentation to Health Net. Before paying your claim, your health plan may require you to provide information and submit documentation necessary to determine whether the services are covered under your plan.

4. If you do not pay directly for a health care service, your health care <facility/provider> may be responsible for submitting claim documentation to your health plan for the health care service.

Your signature below acknowledges that you received this notice before paying a <facility/provider> directly for a health care service.

Signature: _____ Date: _____

Print Name: _____

13-424a

PROVIDER*Update*

Health Net®

CONTRACTUAL | NOVEMBER 13, 2013 | UPDATE 13-481 | 1 PAGE

Medical Record Documentation Standards

This update provides an overview of performance measurements and goals, and a sample of best practices for medical record documentation standards. Health Net's standards for administration of medical records ensure that they conform to good professional medical practice, support health management and permit effective member care.

PERFORMANCE MEASUREMENT AND GOALS

Health Net monitors medical record documentation through a number of measures, which include, but are not limited to, various quality initiatives, data collection by way of primary care physician (PCP) medical record audits and records collected through the Healthcare Effectiveness Data and Information Set (HEDIS®[1]) process. Health Net identifies opportunities for improvement and implements appropriate interventions based on compliance levels established for each activity.

DOCUMENTATION STANDARDS

Providers must create a medical record upon each member's initial visit. The following list highlights some, but not all, expectations for medical record documentation:

- Date of service must be clearly documented on each unique record document
- Formatting – biographical member data and physician signature must be on all medical records (paper and electronic) in accordance with ICD-9 guidelines
- Detailed recording – patient allergies must be noted prominently, chronic problems must be listed, ongoing/continuous medications must be easily identified, and current diagnosis codes must be documented
- Care coordination – instructions for follow-up care must be noted in chart, working diagnosis must be consistent with findings, and practitioner review of diagnostic tests/consultant reports must be documented
- Preventive care – age-appropriate periodic health evaluations must be noted in chart (pediatric and adult), as well as documentation of tuberculosis (TB) screening, and assessment/documentation of pediatric immunization status

Additional information about medical record documentation standards and forms is available on the Health Net provider website at provider.healthnet.com, in the Health Net Provider Library > *Operations Manuals* > *Medical Records*.

ADDITIONAL INFORMATION

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

[1] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- ● Primary Care Physicians
- ● Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

LINES OF BUSINESS:

- ● Advantage Platinum (HMO)
- ● Advantage Platinum (PPO, POS)
- ● Medicare Advantage (HMO)
- ● Health Net Access (AHCCCS)

PROVIDER SERVICES

az_internetproviderinquiries@healthnet.com
HMO, PPO, POS, & Medicare Advantage – (800) 289-2818
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PROVIDER*Update*

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CONTRACTUAL | NOVEMBER 6, 2013 | UPDATE 13-464 | 1 PAGE

Hiring Non-Participating Providers

In order to comply with applicable federal and state laws and regulations, Health Net requires that all participating providers in Health Net's network adhere to the following standards when hiring non-participating providers to render services to Health Net members.

Health Net's participating providers must be able to demonstrate that each non-participating provider has the following supporting documentation:

- Current, unencumbered state medical license
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate 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

Additionally, practitioners must be absent from the following:

- Sanctions that would not allow them to treat Medicare members, if applicable
- 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 employee members

Health Net's participating providers are responsible for ongoing monitoring of sanctions and licensing validation. All Health Net participating providers must 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)*.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Credentialing Department at (818) 676-7860. For all other questions, contact the Health Net Provider Services Center as listed in the right-hand column.

Provider-Relevant Articles Online

Access informative Online News articles today by logging in to provider.healthnet.com. Select the rotating graphic to read or print the articles of interest. Health Net posts new articles each week that cover a variety of topics, such as health plan updates, administrative procedure reminders, quality improvement tips, and health care initiatives.

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- ● Physicians
- ● Medical Groups/IPAs
- ○ Hospitals
- ○ Ancillary Providers

LINES OF BUSINESS:

- ● Advantage Platinum (HMO)
- ● Advantage Platinum (PPO, POS)
- ● Medicare Advantage (HMO)
- ● Health Net Access (AHCCCS)

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NATIONAL PROVIDER COMMUNICATIONS

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fax (800) 937-6086

Health Net of Arizona, Inc.
Health Net Access, Inc.
Health Net Life Insurance Company
1230 W. Washington St., Suite 401
Tempe, Arizona 85281
602.794.1400
800.289.2818

www.healthnet.com

November 4, 2013

<Entity Name>
<First name> <Last name>, <Title> ***or*** Administrator
<Address>
<City>, <State> <ZIP>

Dear <Title>. <Last Name> ***or*** Administrator:

In an ongoing effort to provide our members with the most appropriate care, Health Net of Arizona is requesting that its participating providers complete the attached survey regarding the services each office provides to Health Net members.

Your response is very important to Health Net. Please return the survey no later than **November 29, 2013,** via fax to Health Net Provider Network Management at (602) 794-1803 or by mail to:

Health Net of Arizona
Health Net Provider Network Management
1230 W. Washington Street #401
Tempe, AZ 85281

Health Net will use the results of this survey to assist members in selecting providers who best meet their health care needs.

If you have additional comments or would like to speak with a Health Net Provider Network Management representative, please check "Yes" to question 11.

Health Net appreciates your input and ongoing dedication to providing quality health care services.

Sincerely,

Ann Peacock
Manager, Provider Network Management

Enclosure

13-445

Health Net®

2013 HEALTH NET OF ARIZONA PRACTITIONER SURVEY

Please complete the following survey and fax or mail as listed below by **November 29, 2013**:
Fax: (602) 794-1803
Health Net of Arizona – Provider Network Management
1230 W. Washington St #401
Tempe, AZ 85281

If answers apply to all providers in the practice, complete one survey for the practice. If answers apply to specific providers within the practice, please complete a separate survey for each provider.

1. Which of the following services do you provide for individuals with special needs/chronic conditions (*check all that apply*)?
☐ Physical ☐ Developmental ☐ Behavioral ☐ Emotional ☐ None

2. Do you provide services to individuals who have difficulty communicating or cooperating (for example, those with autism or intellectual disabilities)? ☐ Yes ☐ No

3. Do you provide services to individuals with mobility limitations (such as those who are wheelchair bound)?
☐ Yes ☐ No

4. Do you treat any of the following diagnoses (*check all that apply*)?
☐ Anxiety ☐ ADHD ☐ Depression ☐ HIV* ☐ None
*****Meets one of the criteria below:
   a. Current board certification or recertification in infectious diseases
   b. Annual completion of at least 10 hours of HIV/AIDS-related continuing medical education (CME), which meet the CME requirements under A.A.C. R4-16-101

5. **Primary care physicians (PCPs) and obstetricians (OBs):** Which of the following services do you provide (*check all that apply*)? ☐ EPSDT ☐ OB ☐ Neither

6. Do you participate in the Vaccines for Children (VFC) program?
☐ Yes – VFC PIN code: _____ ☐ No (*PCPs seeing AHCCCS members ages 18 & younger must participate*)

7. Are you a Baby Arizona provider? ☐ Yes ☐ No

8. Is your practice/clinic a federally qualified health center (FQHC) or regional health center (RHC)?
☐ FQHC ☐ RHC ☐ No

9. **PCPs only:** Patient age range: _____

10. Provider staff language (other than English): _____

11. I would like to speak with a Provider Network Representative regarding this survey: ☐ Yes ☐ No

Please complete the following information:

Practice name:_____Tax ID#: _____

National Provider Identifier (NPI) (only required if survey does not apply to entire practice): _____

Provider name:_____

Practice manager name:_____ Telephone #:_____

PROVIDER*Update*

CONTRACTUAL | OCTOBER 22, 2013 | UPDATE 13-387 | 2 PAGES

Health Net®

Provider-Preventable Conditions

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 and reduces or prohibits payments for provider-preventable conditions (PPCs) and surgical errors as defined in this communication.

The Centers for Medicare and Medicaid Services (CMS) issued a final rule implementing section 2702, which reduces or prohibits payments related to PPCs. 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 list as defined in the Other Provider-Preventable Condition section below.

DEFINITIONS

PPCs are defined as health care-acquired conditions (HCACs) or OPPCs as listed below.

Health Care-Acquired Condition

An 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

An OPPC applies to Medicaid inpatient or outpatient health care settings and includes any of the three Medicare National Coverage Determinations:

- Surgery on the wrong patient

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- ● Physicians
- ○ Medical Groups/IPAs
- ● Hospitals
- ● Ancillary Providers

LINES OF BUSINESS:

- ○ Advantage Platinum (HMO)
- ○ Advantage Platinum (PPO, POS)
- ○ Medicare Advantage (HMO)
- ● Health Net Access (AHCCCS)

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fax (800) 937-6086

- 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 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

Providers must use the Potential Quality Issue (PQI) Referral Form to report a PPC. The form is available on Health Net's provider website in the Provider Library at provider.healthnet.com > *Working with Health Net* > *Contractual* > *Policy Library* > *Go to the Provider Library* > *Forms*. Submit the completed form directly via secure fax to Health Net at (877) 808-7024 within one business day of the event or occurrence.

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. A list of CMS HAC diagnosis codes is available on the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/FY_2013_Final_HACsCodeList.pdf.

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 be OPPCs:

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

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

PROVIDER*Update*

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NEWS & ANNOUNCEMENTS | OCTOBER 11, 2013 | UPDATE 13-378sum | 2 PAGES

Summary Update: *2013-2014 Influenza Vaccine Recommendations*

On August 30, 2013, the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP) released the Prevention and Control of Influenza with Vaccines Report (62 Early Release) regarding the use of vaccines to prevent and control influenza for the 2013-2014 season. This summary update contains influenza vaccine recommendations for the 2013-2014 season. Comprehensive information regarding the influenza vaccine is available in the complete update 13-378, *2013-2014 Influenza Vaccine Recommendations*. To view update 13-378, visit the Health Net provider website at provider.healthnet.com > *Updates and Letters* > *2013*.

INFLUENZA RECOMMENDATIONS

The influenza A (H3N2) and B antigens differ from 2011-2012 and 2012-2013. Annual vaccination is recommended, even for those who received the vaccine in the 2012-2013 season, for optimal protection against influenza. The following are the vaccine recommendations and coverage for 2013-2014:

- Routine influenza vaccination is recommended for all individuals ages six months and older, which is supported by evidence that annual influenza vaccination is a safe and effective preventive health action with potential benefit in all age groups. This recommendation seeks to remove barriers to influenza immunization and signals the importance of preventing influenza across the entire population
- Annual influenza vaccination is a safe and preventive health action that benefits all age groups. However, certain individuals have a higher risk for influenza complications, including individuals ages 65 and older, pregnant women and adults between ages 25 and 64 with certain chronic medical conditions. These people, their household and close contacts, and all health care personnel should continue to be a primary focus for vaccination efforts. In addition, children younger than six months are not eligible for vaccination and vulnerable; their caregivers should be vaccinated
- Children ages six months through eight years who have never received an influenza vaccine require two doses, administered a minimum of four weeks apart, during their first season of vaccination to optimize immune response
- Children ages six months through eight years need only one dose of vaccine in 2013-2014 if they received a total of two or more doses of seasonal vaccine since July 1, 2010. Children who did not receive a total of two or more doses of seasonal vaccine since July 1, 2010, require two doses in 2013-2014
- If a child six months through eight years is known to have received at least two seasonal influenza vaccines during any previous season, and at least one dose of a 2009 H1N1-containing vaccine (that is either the 2010-2011, 2011-2012 or 2012-2013 seasonal vaccine, or the monovalent 2009 (H1N1) vaccine), then the child needs only one dose for 2013-2014. Using this approach, children ages six months through eight years need only one dose of vaccine in 2013-2014 if they have received any of the following (children for whom one of these conditions is not met require two doses in 2013-2014):

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- Physicians
- Medical Groups/IPAs
- Hospitals
- Ancillary Providers

LINES OF BUSINESS:

- Advantage Platinum (HMO)
- Advantage Platinum (PPO, POS)
- Medicare Advantage (HMO)
- Health Net Access (AHCCCS)

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fax (800) 937-6086

- Two or more doses of seasonal influenza vaccine since July 1, 2010
- Two or more doses of seasonal influenza vaccine before July 1, 2010, and one or more doses of monovalent 2009 (H1N1) vaccine
- One or more doses of seasonal influenza vaccine before July 1, 2010, and one or more doses of seasonal influenza vaccine since July 1, 2010

- U.S. influenza vaccines for 2013-2014 contain A/California/7/2009 (H1N1)-like, A/Victoria/361/2011 (H3N2)-like, and B/Massachusetts/2/2012-like virus. Quadrivalent vaccines include additional vaccine virus, a B/Wisconsin/1/2010-like virus
- Fluarix® is an inactivated influenza vaccine (IIV4) for individuals ages 3 and older
- FluBlok® (Protein Sciences) is a recombinant hemagglutinin influenza vaccine (RIV3) available for adults ages 18 to 49
- Fluzone® (Sanofi Pasteur) is an alternative inactivated vaccine for adults ages 65 and older. Adults ages 65 and older can receive any of the standard-dose IIV preparations or Fluzone High-Dose; no preference is indicated
  - Adults under age 65 who receive inactivated influenza vaccine should receive a standard-dose IIV preparation
- Fluzone Quadrivalent (IIV4), in addition to the previous trivalent formulation, is recommended for individuals ages six months and older
- Fluzone Intradermal was licensed in May 2011. This vaccine is an alternative to other IIV preparations for individuals ages 18 to 64 years with no preferential recommendation
- FluMist (MedImmune), the intranasally administered live attenuated influenza vaccine (LAIV4), is indicated for healthy, nonpregnant individuals ages 2 through 49

CLAIM SUBMISSION FOR THE INFLUENZA VACCINE

Upon submission of a claim, Health Net reimbursement to providers is in accordance with the terms of the provider's Health Net *Provider Participation Agreement* (*PPA*) and the member's benefit plan design. Refer to the Seasonal Influenza Vaccine Codes table for coding information in the complete update 13-378, *2013-2014 Influenza Vaccine Recommendations* on the Health Net provider website at provider.healthnet.com > *Updates and Letters* > *2013*.

Health care providers should begin offering vaccinations as soon as they become available. Since influenza may not appear in certain communities until February or March, the vaccine should continue to be offered throughout flu season as long as it is available.

The complete update 13-378, *2013-2014 Influenza Vaccine Recommendations*, on the Health Net provider website at provider.healthnet.com > *Updates and Letters* > *2013* also includes information regarding:

- Detailed ACIP recommendations, which are also available online at www.cdc.gov/flu
- Vaccine distribution and ordering instructions, which are available online at www.preventinfluenza.org
- CDC recommendations for use of influenza antiviral medicines (Relenza® (zanamivir) and Tamiflu® (oseltamivir)) for treatment and prevention (chemoprophylaxis) of influenza during the upcoming flu season
- National Influenza Vaccination Week (NIVW) – Beginning December 8, 2013
- Information on different indications as outlined in the Recommended Influenza Vaccines for the United States 2013-2014 Season table

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center at:

Line of Business	Telephone Number	Email Address
HMO, PPO, POS, & MEDICARE ADVANTAGE	(800) 289-2818	AZ_InternetProviderInquiries@healthnet.com
HEALTH NET ACCESS	(888) 788-4408	

PROVIDER*Update*

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NEWS & ANNOUNCEMENTS | OCTOBER 11, 2013 | UPDATE 13-378 | 6 PAGES

2013-2014 Influenza Vaccine Recommendations

On August 30, 2013, the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP) released the Prevention and Control of Influenza with Vaccines Report (62 Early Release) regarding the use of vaccines to prevent and control influenza for the 2013-2014 season. This update contains influenza vaccine recommendations for the 2013-2014 season. Information in this update is adapted from ACIP's Prevention and Control of Influenza with Vaccines Report.

Vaccine recommendations apply only to individuals who do not have contraindications to vaccine use. Different influenza vaccine preparations have different indications as licensed by the United States Food and Drug Administration (FDA). Refer to the Recommended Influenza Vaccines for the United States 2013-2014 Season table on page 5 of this update for an overview of these indications. For the most current information regarding influenza vaccine recommendations, visit the CDC website at www.cdc.gov/flu.

The influenza A (H3N2) and B antigens differ from 2011-2012 and 2012-2013. Annual vaccination is recommended, even for those who received the vaccine in the 2012-2013 season, for optimal protection against influenza. The following are the vaccine recommendations and coverage for 2013-2014:

- Routine influenza vaccination is recommended for all individuals ages six months and older, which is supported by evidence that annual influenza vaccination is a safe and effective preventive health action with potential benefit in all age groups. This recommendation seeks to remove barriers to influenza immunization and signals the importance of preventing influenza across the entire population
- Annual influenza vaccination is a safe and preventive health action that benefits all age groups. However, certain individuals have a higher risk for influenza complications, including individuals ages 65 and older, pregnant women and adults between ages 25 and 64 with certain chronic medical conditions. These people, their household and close contacts, and all health care personnel should continue to be a primary focus for vaccination efforts. In addition, children younger than six months are not eligible for vaccination and vulnerable; their caregivers should be vaccinated
- Children ages six months through eight years who have never received an influenza vaccine require two doses, administered a minimum of four weeks apart, during their first season of vaccination to optimize immune response
- Children ages six months through eight years need only one dose of vaccine in 2013-2014 if they received a total of two or more doses of seasonal vaccine since July 1, 2010. Children who did not receive a total of two or more doses of seasonal vaccine since July 1, 2010, require two doses in 2013-2014
- If a child six months through eight years is known to have received at least two seasonal influenza vaccines during any previous season, and at least one dose of a 2009 H1N1-containing vaccine (that is either the 2010-2011, 2011-2012 or 2012-2013 seasonal vaccine, or the monovalent 2009 (H1N1) vaccine), then the child needs only one dose for 2013-2014. Using this approach, children ages six months through eight years need only one dose of vaccine in 2013-2014 if they have received any of the following (children for whom one of these conditions is not met require two doses in 2013-2014):

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- Physicians
- Medical Groups/IPAs
- Hospitals
- Ancillary Providers

LINES OF BUSINESS:

- Advantage Platinum (HMO)
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- Two or more doses of seasonal influenza vaccine since July 1, 2010
- Two or more doses of seasonal influenza vaccine before July 1, 2010, and one or more doses of monovalent 2009 (H1N1) vaccine
- One or more doses of seasonal influenza vaccine before July 1, 2010, and one or more doses of seasonal influenza vaccine since July 1, 2010

- U.S. influenza vaccines for 2013-2014 contain A/California/7/2009 (H1N1)-like, A/Victoria/361/2011 (H3N2)-like, and B/Massachusetts/2/2012-like virus. Quadrivalent vaccines include additional vaccine virus, a B/Wisconsin/1/2010-like virus
- Fluarix® is an inactivated influenza vaccine (IIV4) for individuals ages 3 and older
- FluBlok® (Protein Sciences) is a recombinant hemagglutinin influenza vaccine (RIV3) available for adults ages 18 to 49
- Fluzone® (Sanofi Pasteur) is an alternative inactivated vaccine for adults ages 65 and older. Adults ages 65 and older can receive any of the standard-dose IIV preparations or Fluzone High-Dose; no preference is indicated
  - Adults under age 65 who receive inactivated influenza vaccine should receive a standard-dose IIV preparation
- Fluzone Quadrivalent (IIV4), in addition to the previous trivalent formulation, is recommended for individuals ages six months and older
- Fluzone Intradermal was licensed in May 2011. This vaccine is an alternative to other IIV preparations for individuals ages 18 to 64 years with no preferential recommendation
- FluMist (MedImmune), the intranasally administered live attenuated influenza vaccine (LAIV4), is indicated for healthy, nonpregnant individuals ages 2 through 49

ADMINISTRATION RECOMMENDATIONS

- IIV preparations with the exception of Fluzone Intradermal should be administered via the intramuscular route. For adults and older children, the deltoid is the preferred site. Infants and younger children should be vaccinated in the anterolateral thigh, whereas the LAIV, FluMist, is intended for intranasal administration only
- Fluzone Intradermal is indicated for individuals ages 18 through 64
- Fluzone High-Dose is indicated for adults ages 65 and older
- LAIV should not be administered to pregnant women, individuals under age 2 or over 49; adults and children with chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, neurologic/neuromuscular, hematologic, or metabolic disorders; children ages 2 to 4 with asthma or wheezing in the preceding 12 months; adults and children with immunosuppression or their close contacts; and individuals ages six months to 18 years receiving aspirin or other salicylates
- Women who are or will be pregnant during influenza season should receive IIV
- Postpartum women can receive LAIV or IIV
- Individuals with a history of egg allergy who report only hives after egg exposure should receive IIV or RIV rather than LAIV. Vaccine recipients should be observed for at least 30 minutes for signs of a reaction after administration of each vaccine dose
- IIV and LAIV are contraindicated in individuals known to have anaphylactic hypersensitivity to eggs or to other components of the influenza vaccine
- All children ages six months through eight years who did not receive at least one dose of the 2011-2012 seasonal influenza vaccine, or for whom it is not certain whether the 2012-2013 seasonal vaccine was received, should receive two doses of the 2013-2014 seasonal influenza vaccine at least four weeks apart
- As a precaution, individuals who are not at high risk for severe influenza complications and who are known to have experienced Guillain-Barré Syndrome (GBS) within six weeks of receipt of an influenza vaccine (IIV or LAIV), generally should not be vaccinated

Health care providers should begin offering vaccinations as soon as they become available. Since influenza may not appear in certain communities until February or March, the vaccine should continue to be offered throughout the flu season as long as it is available.

Health care administrators should consider the level of vaccination coverage among health care personnel (HCP) to be one measure of a patient safety quality program and implement policies to encourage HCP vaccination (for example, obtain signed statements from HCP who decline influenza vaccination).

Providers may access detailed ACIP recommendations online at www.cdc.gov/flu.

VACCINE DISTRIBUTION AND ORDERING INSTRUCTIONS

The influenza vaccine is being distributed through local vendors and distributors. For the 2013-2014 season, most preparations are available for purchase. Information about distributors who have influenza vaccine is available online at www.preventinfluenza.org.

CLAIM SUBMISSION FOR THE INFLUENZA VACCINE

Upon submission of a claim, Health Net reimbursement to providers is in accordance with the terms of the provider's Health Net *Provider Participation Agreement* (*PPA*) and the member's benefit plan design. Refer to the Seasonal Influenza Vaccine Codes table on page 4 for coding information.

RELENZA® AND TAMIFLU® TREATMENT FOR INFLUENZA

While the flu vaccine is the best protection against influenza viruses, CDC also provides recommendations for use of influenza antiviral medicines (Relenza® (zanamivir) and Tamiflu® (oseltamivir)) for treatment and prevention (chemoprophylaxis) of influenza during the upcoming flu season. For 2013-2014, priority use of antiviral medications continues to be for individuals hospitalized with influenza and those at increased risk of influenza-related complications. Most healthy individuals with the flu do not need to be treated with antiviral medications.

Priority for the use of oral antiviral medications in the 2013-2014 season are:

- Individuals with suspected or confirmed influenza requiring hospitalization
- Individuals with suspected or confirmed influenza who are at higher risk for complications, including:
  - Children younger than age 2
  - Individuals ages 65 or older
  - Individuals with certain chronic medical conditions (such as asthma, heart failure or chronic lung disease) and those with a weak immune system (due to illnesses such as diabetes and HIV)
  - Individuals younger than age 19 who are receiving long-term aspirin therapy

Children ages 2 to 4 are more likely to require hospitalization or urgent medical evaluation for influenza compared with older children, although the risk is much lower for 2- to 4-year-olds than for children younger than age 2. Children ages 2 through 4 without high-risk conditions and with mild illness do not necessarily require antiviral treatment.

Coverage for zanamivir and oseltamivir is subject to Health Net's benefit plan terms and conditions. Refer to the CDC website at www.cdc.gov/flu/antivirals/index.htm for up-to-date information on the recommendations for the use of influenza antiviral medications.

NATIONAL INFLUENZA VACCINATION WEEK

The week of December 8, 2013, is nationally observed as National Influenza Vaccination Week (NIVW). NIVW was established to highlight the importance of continuing influenza vaccination, as well as fostering greater use of flu vaccine after the holiday season into January and beyond.

CDC is supporting organizations and providers across the country in their vaccination efforts during NIVW. Visit the CDC website at www.cdc.gov/flu/NIVW/resources.htm for print materials, Web tools (banners, buttons and badges that can be added to a website), audio/video tools, and public service announcements that promote vaccination.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center at:

Line of Business	Telephone Number	Email Address
HMO, PPO, POS, & MEDICARE ADVANTAGE	(800) 289-2818	AZ_InternetProviderInquiries@healthnet.com
HEALTH NET ACCESS	(888) 788-4408	

SEASONAL INFLUENZA VACCINE CODES[1]

CPT/HCPCS Code	Code Description
ADMINISTRATION CODES	
90460	Immunization administration through age 18 via any route of administration, includes counseling of the patient/family; first injection (single or combination vaccine/toxoid)
90461	Each additional immunization administration (list separately in addition to code for primary procedure)
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)
90473	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)
G0008 (Medicare Advantage only)	Administration of influenza virus vaccine
VACCINE CODES	
90655	Influenza virus vaccine, trivalent, split virus, preservative-free, when administered to children ages 6-35 months, for intramuscular use
90656	Influenza virus vaccine, trivalent, split virus, preservative-free, for use when administered to individuals ages 3 and older, for intramuscular use
90657	Influenza virus vaccine, trivalent, split virus, when administered to children ages 6-35 months, for intramuscular use
90658	Influenza virus vaccine, trivalent, split virus, when administered to children ages 3 and older, for intramuscular use
90660	Influenza virus vaccine, trivalent, live, for intranasal use, for individuals ages 2 and older
90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative- and antibiotic-free, for intramuscular use
90662	Influenza virus vaccine, preservative-free, enhanced immunogenicity via increased antigen content
90664	Influenza virus vaccine, pandemic formulation, live, for intranasal use (vaccine pending FDA approval)
90666	Influenza virus vaccine, pandemic formulation, split virus, preservative-free, for intramuscular use (vaccine pending FDA approval)
90667	Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use (vaccine pending FDA approval)
90668	Influenza virus vaccine, pandemic formulation, split virus, for intramuscular route (vaccine pending FDA approval)
90672	Influenza virus vaccine, quadrivalent, live, for intranasal use (code price is per dose – 0.2 mL)
90685	Influenza virus vaccine, quadrivalent, split virus, preservative-free, when administered to children 6-35 months of age, for intramuscular use (code price is per 0.25 mL)
90686	Influenza virus vaccine, quadrivalent, split virus, preservative-free, when administered to individuals 3 years of age and older, for intramuscular use (code price is per 0.5 mL)

[1] CPT code descriptions were taken from the 2011 AMA CPT Code Handbook. HCPCS code descriptions were taken from the CMS HCPCS Code Sets.

RECOMMENDED INFLUENZA VACCINES FOR THE UNITED STATES 2013-2014 SEASON[2]

VACCINE	TRADE NAME	MANUFACTURER	PRESENTATION	MERCURY CONTENT (MCG HG/0.5 ML DOSE)	AGE GROUP	NO. OF DOSES	ROUTE
IIV3	Afluria®	CSL Limited	0.5 ml prefilled syringe	0	≥ 9 years[3]	1	IM[4]
			5.0 ml multidose vial	24.5	≥ 9 years	1 or 2	IM[4]
IIV3	Fluarix®	GlaxoSmithKline	0.5 ml prefilled syringe	0	≥ 3 years	1	IM[4]
IIV3	Flucelvax®[5]	Novartis Vaccines	0.5 ml prefilled syringe	0	≥ 18 years	1	IM[4]
IIV3	FluLaval®	ID Biomedical Corp. of Quebec, a subsidiary of GlaxoSmithKine	5.0 ml multidose vial	25	≥ 3 years	1 or 2	IM[4]
IIV3	Fluvirin®	Novartis Vaccine	0.5 ml prefilled syringe	<1.0	≥ 4 years	1 or 2	IM[4]
			5.0 ml multidose vial	25	≥ 4 years	1 or 2	IM[4]
IIV3	Fluzone®	Sanofi Pasteur	0.25 ml prefilled syringe	0	6 to 35 months	1 or 2[6]	IM[4]
			0.5 ml prefilled syringe	0	≥ 36 months	1 or 2[6]	IM[4]
			0.5 ml vial	0	≥ 36 months	1 or 2[6]	IM[4]
			5.0 ml multidose vial	25	≥ 6 months	1 or 2[6]	IM[4]
IIV3	Fluzone Intradermal[7]	Sanofi Pasteur	0.1 ml prefilled microinjection system	0	18 to 64 years	1[6]	ID[8]
IIV3 high dose[9]	Fluzone High-Dose	Sanofi Pasteur	0.5 ml prefilled syringe	0	≥ 65 years	1[6]	IM[4]
IIV4	Fluarix Quadrivalent	GlaxoSmithKline	0.5 ml prefilled syringe	0	≥ 3 years	1	IM[4]
IIV4	FluLaval Quadrivalent	ID Biomedical Corp. of Quebec, a subsidiary of GlaxoSmithKine	5.0 ml multidose vial	25	≥ 3 years	1 or 2	IM[4]
IIV4	Fluzone Quadrivalent	Sanofi Pasteur	0.25 ml prefilled syringe	0	6 to 35 months	1[6]	IM[4]
			0.5 ml prefilled syringe	0	≥ 36 months	1[6]	IM[4]
			0.5 ml vial	0	≥ 36 months	1[6]	IM[4]
RIV3	FluBlok® Quadrivalent	Protein Sciences	0.5 ml vial	0	18 to 49 years	1	IM[4]
LAIV4	FluMist® Quadrivalent[10]	MedImmune	0.2 ml prefilled intranasal sprayer	0	2 to 49 years	1 or 2[11]	IN

Abbreviations: IIV = inactivated influenza vaccine; LAIV = live-attenuated influenza vaccine; IM = intramuscular; ID = intradermal; IN = intranasal; RIV = recombinant heagglutinin influenza vaccine.

[2] Adapted from Recommended Influenza Vaccines for the U.S. 2013-2014 season table on the CDC website at www.cdc.gov/flu/about/qa/vaxsupply.htm.

[3] Age indication per package insert is for individuals ages 5 and older; however, the ACIP recommends Afluria not be used in children ages 6 months through 8 years because of increased risk of febrile reactions noted in this age group with CSL's 2010 Southern Hemisphere IIV3. If no other age-appropriate, licensed inactivated seasonal influenza vaccine is available for a child age 5 to 8 who has a medical condition that increases the child's risk for influenza complications, Afluria can be used; however, providers should discuss with the parents or caregivers the benefits and risks of influenza vaccination with Afluria before administering this vaccine. Afluria may be used in individuals ages 9 and older.

[4] For adults and older children, the recommended site of vaccination is the deltoid muscle. The preferred site for infants and young children is the anterolateral aspect of the thigh. Specific guidance regarding site and needle length for intramuscular administration may be found in the ACIP General Recommendations on Immunization.

[5] Information not included in package insert. The total egg protein is estimated to be less than 50 femtograms (5 x 10-14 grams) total egg protein, of which a fraction is ovalbumin, per 0.5 mL dose of Flucelvax.

[6] Available upon request from upon request from Sanofi Pasteur, by telephone at (800) 822-2463, or email at MIS.Emails@sanofipasteur.com.

[7] Inactivated influenza vaccine, intradermal: A 0.1-mL dose contains 9 µg of each vaccine antigen (27 µg total).

[8] The preferred site is over the deltoid muscle. Fluzone Intradermal is administered using the delivery system included with the vaccine.

[9] Inactivated influenza vaccine, high-dose: A 0.5-mL dose contains 60 µg of each vaccine antigen (180 µg total).

[10] It is anticipated that the quadrivalent formulation of FluMist will replace the trivalent formulation for the 2013-14 season. FluMist is shipped refrigerated and stored in the refrigerator at 35°F–46°F (2°C–8°C) after arrival in the vaccination clinic. The dose is 0.2 mL divided equally between each nostril. Health-care providers should consult the medical record, when available, to identify children ages 2 to 4 with asthma or recurrent wheezing that might indicate asthma. In addition, to identify children who might be at greater risk for asthma and possibly at increased risk for wheezing after receiving LAIV, parents or caregivers of children ages 2 to 4 should be asked: "In the past 12 months, has a health-care provider ever told you that your child had wheezing or asthma?" Children whose parents or caregivers answer "yes" to this question and children who have asthma or who had a wheezing episode noted in the medical record within the past 12 months should not receive FluMist.

[11] Flumist is indicated for healthy, non-pregnant individuals ages 2 to 49. Individuals who care for severely immunosuppressed individuals who require a protective environment should not receive FluMist given the theoretical risk of transmission of the live attenuated vaccine virus.

PROVIDER*Update*

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MedSolutions to Review Outpatient Diagnostic Imaging Requests for Health Net Access Members

Health Net has signed an agreement with MedSolutions to review outpatient diagnostic imaging prior authorization requests for Health Net Access members, effective November 1, 2013.

On and after November 1, 2013, prior authorization requests for the following outpatient diagnostic imaging requests must be submitted to MedSolutions via telephone at (888) 693-3211 or fax at (888) 693-3210:

- Computed tomography (CT)
- Magnetic resonance angiography (MRA) scans
- Magnetic resonance imaging (MRI) scans
- Nuclear cardiac imaging procedures
- Positron emission tomography (PET)

ACCESS PRIOR AUTHORIZATION REQUIREMENTS LIST

The prior authorization requirements list for Health Net Access has been updated with the change to contact MedSolutions for outpatient diagnostic procedures, and will be available online as of November 1, 2013. Currently effective requirements are available on the Health Net provider website at provider.healthnet.com under *Working With Health Net* > *Contractual* > *Services Requiring Prior Authorization*, and under *Provider Library* > *Operations Manuals* > *Prior Authorization*. Health Net's prior authorization policies and procedures are also available in the operations manuals.

ADDITIONAL INFORMATION

If you have questions regarding the information in this update, contact the Health Net Access Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

Discover Helpful Tools to Support Your Office

The Provider Library online at provider.healthnet.com allows participating providers to quickly access pertinent information to assist in their everyday interaction with Health Net. The Provider Library includes operations manuals, communications (updates and letters), Online News articles, forms, Health Net contact information, and more.

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

- ● Physicians
- ● Medical Groups/IPAs
- ● Hospitals
- ● Ancillary Providers

LINES OF BUSINESS:

- ○ Advantage Platinum (HMO)
- ○ Advantage Platinum (PPO, POS)
- ○ Medicare Advantage (HMO)
- ● Health Net Access (AHCCCS)

PROVIDER SERVICES

az_internetproviderinquiries@healthnet.com
(888) 788-4408
www.healthnet.com

NATIONAL PROVIDER COMMUNICATIONS

provider.communications@healthnet.com
fax (800) 937-6086

PROVIDER*Update*

CONTRACTUAL | SEPTEMBER 6, 2013 | UPDATE 13-325 | 5 PAGES

Health Net Access Provider Operational Information and Prior Authorization Requirements

Health Net Access, Inc. (Health Net), a subsidiary of Health Net, Inc., is a contractor for the Arizona Health Care Cost Containment System (AHCCCS). Effective October 1, 2013, Health Net launches the Health Net Access plan, a Medicaid managed care plan, in Maricopa County. Health Net has developed a comprehensive set of operational materials for participating providers, including electronic operations manuals and an orientation packet. This update provides information on the operational resources and prior authorization requirements for Health Net Access members.

HEALTH NET ACCESS PROVIDER OPERATIONS MANUALS

Available now at provider.healthnet.com, the Health Net Access provider operations manuals offer participating providers necessary procedural information to ensure Health Net Access members receive appropriate covered services when needed. The manuals were developed specifically for physicians and hospitals serving Health Net Access members. The contents of the manuals are supplemental to the *Provider Participation Agreement* (*PPA*) and its addendums.

The manuals are located on the Health Net provider website at provider.healthnet.com in the Provider Library. The Provider Library includes operational materials targeted to provider type, including operations manuals, provider updates and letters, contacts, and forms. To access the Provider Library, participating providers must register online at provider.healthnet.com.

PROVIDER ORIENTATION PACKET

At the beginning of September, Health Net is distributing to Health Net Access participating providers an educational packet of operational materials as a supplement to the comprehensive provider operations manuals. The materials were developed to help providers and office staffs become familiar with the Health Net Access plan and provide quick reference to contacts and resources. The packet includes the following:

- Health Net Access Provider Reference Guide
- *Making Practice Perfect - Tools for Working Efficiently with Health Net* provider toolkit
- Provider Library brochure
- *Unlock the Advantages of HealthNet.com* brochure
- Interpreter services reference sheet
- Health Net Access quality management program description
- *Better Communication, Better Care: Provider Tools to Care for Diverse Populations* toolkit

THIS UPDATE APPLIES TO **ARIZONA** PROVIDERS:

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LINES OF BUSINESS:

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- ○ Advantage Platinum (PPO, POS)
- ○ Medicare Advantage (HMO)
- ● Health Net Access (AHCCCS)

PROVIDER SERVICES

az_internetproviderinquiries@healthnet.com
Health Net Access – (888) 788-4408
www.healthnet.com

NATIONAL PROVIDER COMMUNICATIONS

provider.communications@healthnet.com
fax (800) 937-6086

PRIOR AUTHORIZATION REQUIREMENTS

Prior authorization requirements for Health Net Access plans are available and included with this update for reference. These requirements are effective October 1, 2013.

Providers can also access these requirements on the Health Net provider website at provider.healthnet.com under *Working With Health Net* > *Contractual* > *Services Requiring Prior Authorization*, and in the Health Net Provider Library on the Health Net provider website at provider.healthnet.com. Once in the library, select *Operations Manuals* > *Prior Authorization.* Information regarding prior authorization policies and procedures for the Health Net Access product is also available in the operations manuals.

OUTPATIENT DIAGNOSTIC IMAGING REQUESTS AND REVIEWS

Effective October 1, 2013, prior authorization requests for outpatient diagnostic imaging services for Health Net Access members must be submitted to Health Net, as noted on the attached prior authorization requirements.

Health Net is in discussion with MedSolutions to review diagnostic imaging requests for Health Net Access members, and will communicate any changes in requesting these services in a separate communication.

REGISTERING FOR HEALTHNET.COM

To access the Provider Library online, including the provider operations manuals and prior authorization requirements, providers must register on HealthNet.com. To complete the online registration process, providers need the appropriate tax identification number (TIN) or license number, and relevant personal and organizational information. Register for a Health Net provider website account by completing the following steps:

1. Go to provider.healthnet.com and select *Register*.
2. Review Terms of Use, select *I agree to these terms*, choose the region, then *Continue*.
3. Select the appropriate provider type and complete the required fields.

Select physician, then solo practitioner or delegated administrator, and enter the correct information in the required fields to access the site immediately. A delegated administrator is usually an information technology or office or security manager who is responsible for opening accounts and monitoring employee-level access to the practitioner and provider information on the site.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the Health Net Access Provider Services Center by email at AZ_InternetProviderInquiries@healthnet.com, through the Health Net provider website at provider.healthnet.com, or by telephone at (888) 788-4408.

PRIOR AUTHORIZATION REQUIREMENTS
Health Net Access

Prior Authorization Request Fax Line:
- (855) 764-8513

Prior Authorization Request Telephone Line:
- (888) 926-1736

Forms:
- Health Net Prior Authorization Request – available in the Forms section of the Provider Library on the Health Net provider website at provider.healthnet.com
- Newborn Reporting Form – available in the Forms section of the Provider Library on the Health Net provider website at provider.healthnet.com

Other Contact Information:
- Behavioral health – coordinated by Magellan Health Services, the Regional Behavioral Health Authority (RBHA) in Maricopa County: (800) 564-5465 or www.magellanofaz.com
- Dental Benefit Providers – (855) 866-2620; Health Net Dental, Dental Benefit Providers AZ Medicaid, PO Box 306, Milwaukee, WI 53201
- Eligibility and benefits: provider.healthnet.com or (888) 788-4408
- Health Net Access Member Services Department: (888) 788-4408; TTD/TTY: (888) 788-4872
- Health Net Hospital Notification Unit: (888) 926-1736; fax: (855) 764-8513; after hours and weekends: (888) 926-1736
- Medicaid general information – Arizona Health Care Cost Containment System (AHCCCS): www.azahcccs.gov
- Medications, including self-injectables requiring prior authorization – Health Net Pharmaceutical Services (HNPS): (800) 410-6565; fax: (800) 977-4170

Note: The following services are subject to prior authorization before they are performed in order to be covered. When faxing requests, please attach pertinent medical records, treatment plans, test results, and evidence of conservative treatment to support the medical appropriateness of the request.

Inpatient Services

- Acute rehabilitation facility
- Hospice facility
- Hospital facility
- Newborns – births (including stillborn and unexpected deaths) within 12 hours of delivery[1]
- Nursing facility/skilled nursing facility

Outpatient Procedures/Services/Equipment Prior Authorization Requirements

- **All noncontracting and out-of-state services**
- **Ambulance**
  - Non-emergency air or ground transportation
- **Cardiac and pulmonary rehabilitation therapy**
- **Clinical trials**
- **Cosmetic services, evaluation and procedure**
- **Custom orthotics** – for members under age 21
- **Dental** – contact Dental Benefit Providers at (855) 866-2620
- **Dermatology** (in-office procedures)
  - Skin injections and implants (11900-11980)

[1] Providers are required to complete and submit the Newborn Reporting Form, in conjunction with the Health Net prior authorization request, by secure fax to the Hospital Notification Unit at (855) 764-8513, 8:00 a.m. to 5:00 p.m., Monday through Friday. After hours and on weekends, call (888) 926-1736 for telephone notification.

- **Dermatology** (in-office procedures), continued
  - Skin treatments, including:
    - Chemical exfoliation and electrolysis (17360-17380)
    - Dermabrasion/chemical peel (15780-15793)
    - Laser treatment (17106-17108, 17250)
- **Genetic testing** – covered only to differentiate between treatment options
- **Durable medical equipment (DME)** – for items exceeding $2,500 in billed charges
- **Enteral/parenteral services and supplies**
- **Experimental/investigational services and new technologies**
- **Home health services**
  - Home uterine monitoring
  - Nursing
  - Occupational therapy
  - Physical therapy
  - Speech therapy
  - Tocolytic services
- **Hospice/palliative care**
- **Hyperbaric oxygen therapy**
- **Incontinence briefs** – for members ages 3 to 20
- **Intensity modulated radiation therapy (IMRT)**
- **LifeVest®**
- **Maternity** – at the time of first prenatal visit[2]
- **Neuro or spinal cord stimulator, including procedure**
- **Neuropsych testing**
- **Outpatient diagnostic procedures**
  Fax prior authorization requests to Health Net
  - Computed tomography (CT)
  - Magnetic resonance angiography (MRA) scans
  - Magnetic resonance imaging (MRI) scans
  - Nuclear cardiac imaging procedures
  - Positron emission tomography (PET)
- **Outpatient pharmaceuticals**
  Contact HNPS at (800) 410-6565
  - Hemophilia factors
  - Intravenous (IV)/infusion medications: Actemra®, Aldurazyme®, Aralast™, Benlysta®, Boniva®, Ceredase®, Cerezyme®, Cinryze®, Fabrazyme®, Flolan®, Glassia™, intravenous immunoglobulin (IVIG), Krystexxa®, Lumizyme®, Myozyme®, Naglazyme®, Novantrone®, Orencia®, Prolastin®, Reclast®, Remicade®, Remodulin®, Rituxan® (rheumatoid arthritis only), Tysabri®, Vpriv™, Zemaira®
  - Other medications: Aranesp®, Botox®, Dysport®, Lucentis®, Makena™, Myobloc®, Nplate®, Omontys®, Prolia®, Provenge®, Stelara®, Synagis®, Ventavis®, Xeomin®, Xgeva®, Xiaflex®, Xolair®
  - Self-injectables
- **Outpatient surgical procedures**
  - Back surgery (includes laminotomy, diskectomy, vertebroplasty, and nucleoplasty)
  - Bariatric-related services
  - Blepharoplasty
  - Breast implants removal
  - Breast reconstruction
  - Breast reduction and augmentation
  - Circumcision
  - Cleft palate reconstructive surgery, including dental and orthodontic services
  - Laser-assisted UPPP (LAUP)
  - Orthognathic procedures (includes TMJ treatment)
  - Posterior tibial neuro stimulation/pelvic floor stimulation
  - Pregnancy termination
  - Rhinoplasty

[2] 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), in conjunction with the Health Net prior authorization request.

- **Outpatient surgical procedures, continued**
  - Septoplasty
  - Sterilization
  - Treatment of varicose veins
  - Uvulopalatopharyngoplasty (UPPP)
  - X-Stop
- **Perinatology referral and care**
- **Prosthetics** – for items exceeding $2,500 in billed charges
- **Proton beam therapy**
- **Stereotactic radiosurgery and stereotactic body radiotherapy (SBRT)**
- **Transplant-related services, including evaluation**

Notification Only

- **Dialysis services**
- **Observation services** – contact the Hospital Notification Unit via secure fax at (855) 764-8513, or telephone at (888) 926-1736
- **Urgent/emergent admission as soon as possible, but no later than 24 hours or by the next business day** – notify the Hospital Notification Unit of admissions via secure fax at (855) 764-8513, or telephone at (888) 926-1736

Prior Authorization Limitations and Exclusions

- 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 (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 services and substance abuse services must be referred to RBHA. If coordination assistance with RBHA is needed, contact the Health Net Access Member Services Department
- 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