Provider Reference Guide

Arizona

Herminia Escobedo,
Health Net
We work hard to pay
claims quickly and accurately.

Health Net®

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GENERAL BILLING INFORMATION

Filing a claim

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

Timely filing

When Health Net is the primary payer, claims must be submitted within 120 calendar days of the service date or as set forth in the *Provider Participation Agreement (PPA)* between Health Net and the provider. Claims submitted more than 120 days after the date of service are denied. When Health Net is the secondary payer, claims must be submitted within 60 days of the date on the primary payer's EOP unless the *PPA* includes a different time period. A copy of the primary carrier's EOP must be attached to the claim form.

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

Acceptable proof of timely filing includes:

- Computer-generated billing ledger showing Health Net was billed within Health Net's timely filing limits
- EOP from another insurance carrier dated within Health Net's timely filing limits
- Denial letter from another insurance carrier printed on its letterhead and dated within Health Net's timely filing limits
- Electronic data interchange (EDI) rejection report from clearinghouse that reflects claim was forwarded to Health Net (showing date received versus date of service) that reflects the claim was submitted within Health Net's timely filing limits

Unacceptable proof of timely filing includes:

- Screen-print of claim invoice
- Copy of original claim
- Denial letter from another insurance carrier without a date and not on letterhead
- Record of billing stored in an Excel spreadsheet

All claims must be filed within one year of the date of service under the terms of Health Net coverage.

Minimizing duplicate claims

Providers should not submit a second claim in response to a claim submission for which Health Net has not responded until 45 days after the initial claim submission. Submitting a second claim prior to the 45-day period is costly to providers and Health Net, as the claim payment and resubmission often cross in the mail. Additionally, this may result in duplicate claim submission denials. Providers can verify that their

claims were accepted by submitting a Claims Status request (276/277) via the clearinghouse/vendor or online on the Health Net provider website at provider.healthnet.com.

Special Needs Plan claims submission – Medicare Advantage

The Health Net Medicare Advantage (MA) Special Needs Plan (SNP) – Amber Plan (HMO) is available to individuals who have qualified financial status, as determined by government guidelines.

Full dual-eligible beneficiaries are within the established federal poverty level (FPL) and the government pays for their medical care. Health Net is the primary payer and Medicaid is the secondary payer. Standard claim submission guidelines apply.

Electronic claims

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

The benefits of electronic claim submission include:

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

Table 1: Clearinghouse Information

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

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

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

Reports

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

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

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

Providers may also check the status of paper and electronic claims using the claims status transaction (276/277) on the Health Net provider website at provider.healthnet.com.

EDI questions

For questions regarding electronic claim submission, contact Health Net's dedicated EDI line by telephone at (866) 334-4638, option 4, or by email at edi_support@healthnet.com.

Paper claims submissions

ACS/Health Net of Arizona – Commercial
PO Box 14225
Lexington, KY 40512-4225

ACS/Health Net of Arizona – Medicare
PO Box 14730
Lexington, KY 40512-4225

Clean claim submission guidelines

A "clean claim" is a claim that can be processed as submitted without requiring additional information from the submitting physician, practitioner or facility. Submitted claims that do not meet the clean claim requirements, as outlined on the following pages, may be pended for additional information or denied if the information submitted is invalid.

Upon receipt of notice from Health Net that additional information is required to complete adjudication of the claim, providers must submit only the missing information along with a copy of the notification letter. Providers should not submit a corrected claim in lieu of the additional information.

Upon receipt of a claim, if Health Net determines that additional information is necessary to process the claim, Health Net applies the following steps:

- The claim is contested and Health Net mails a notification letter on the next business day to the provider requesting additional information
- If Health Net does not receive the requested information from the provider within 30 days from the claim contested date, the claim remains denied and Health Net mails a second notification letter to the provider
- If Health Net does not receive the requested information from the provider within 60 days from the claim contested date, the claim remains denied and Health Net mails a final notice to the provider

- If Health Net does not receive the requested information from the provider within 90 days from the claim contested date, the claim remains denied
- For inpatient claims, if Health Net does not receive the requested information from the provider within 45 days from the claim contested date, the claim remains denied and Health Net sends no further notices to the provider

Providers must send all requested information to the address indicated in the letter. If Health Net obtains the requested additional information within 90 days for outpatient claims or 45 days for inpatient claims, from the initial claim contested date, and the information demonstrates the claim should be denied, the claim is denied immediately. Providers should not initiate a new claim after receiving the notification letter requesting additional information. For reference, the notification letter includes the contested claim number that was previously submitted. Once Health Net receives the additional information as requested, the original claim is processed.

If payment is denied based on a provider's failure to comply with clean claim requirements, the claim is treated as nonreimbursable and cannot be billed to the member. Further, claims for MA members must comply with the clean claim requirements for fee-for-service (FFS) Medicare (42 CFR 422.500).

Refer to Table 2: Clean Claim Requirements for specific guidelines.

Table 2: Clean Claim Requirements			
Required Data	CMS 1500 Field	UB-04* Field	Disposition
PATIENT IDENTIFICATION NUMBER	1a	60	Contest requesting valid/missing information.
PATIENT NAME	2	8	Contest requesting valid/missing information.
PATIENT DATE OF BIRTH	3	10	Contest requesting valid/missing information.
NAME OF INSURED	4	58	Contest requesting valid/missing information.
REFERRING, ATTENDING OR OTHER PHYSICIAN'S NAME AND UPIN NUMBER	17	76 and/or 77, 78, 79	If missing and required, contest to obtain additional data.
ICD-9 DIAGNOSIS CODE (UP TO 4 CODES, MUST LINK TO SERVICE CODES)	21	67	Contest requesting valid/missing information.
AUTHORIZATION/REFERRAL NUMBER	23	63	Process and deny if required.
DATE OF SERVICE	24a	6	Contest requesting valid/missing information.
LOCATION OR PLACE OF SERVICE CODE	24b	N/A	Contest requesting valid/missing information.
TYPE OF SERVICE CODE (CMS)/TYPE OF BILL (UB)	24c	10	Contest requesting valid/missing information.
CPT (CMS)/REVENUE CODE (UB)/HCPCS CODE (MUST BE VALID FOR DATE OF SERVICE)	24d	42, 44	Contest requesting valid/missing information.
DIAGNOSIS CODE LINKAGE	24e		Contest requesting valid/missing information.
AMOUNT BILLED	24f	47	Contest requesting valid/missing information.
QUANTITY/UNITS	24g	46	Contest requesting valid/missing information.
NPI/UPIN OF PROVIDER PERFORMING SERVICES	24k	N/A	Contest requesting valid/missing information.
EMERGENCY OR 911 NOTIFICATION	24i	N/A	Contest requesting valid/missing information.
SUBMITTING PROVIDER TAX ID OR SSN	25	5	Contest requesting valid/missing information.
ACCEPTS ASSIGNMENT	27	53	Medicare membership only. Return if missing (non-contracted provider).
PROVIDER NAME	31	1	Contest requesting valid/missing information.

Table 2: Clean Claim Requirements			
Required Data	CMS 1500 Field	UB-04* Field	Disposition
NAME AND ADDRESS OF FACILITY OR ANCILLARY PROVIDER WHERE SERVICES WERE RENDERED	32	N/A	Contest requesting valid/missing information.
PROVIDER BILLING ADDRESS AND PROVIDER ID #	33	1	Contest requesting valid/missing information.
NO EOB ATTACHED FROM PRIMARY INSURER	N/A	N/A	Contest requesting valid/missing information.
NO REPORT ATTACHED, "I.E., OPERATIVE, ER," ETC.	24	N/A	Contest requesting valid/missing information.
PATIENT CONTROL NUMBER	26	3a	Required for Medicare. Pend if missing.
MEDICAL/HEALTH RECORD NUMBER		3b	Required for Medicare. Pend if missing.
RELEASE INFORMATION	12	52	Required for Medicare. Pend if missing.

**For other UB-04 data fields required, refer to the UB-04 Editor Manual.*

Claims questions

For automated claim status information, contact the Customer Contact Center at (800) 289-2818.

Disputing a claim payment or denial

Providers are encouraged to read, understand and follow the requirements for claims appeals outlined in the following pages. Failure to follow the procedures, requirements and deadlines in the appeal process results in a waiver of any right the provider has to proceed to the next level of appeal. Appeal procedures must be exhausted before a provider may exercise arbitration rights under the contract.

Request for appeal

If a participating provider disagrees with a Health Net claim determination, he or she may request a formal appeal. Health Net recommends that providers submit appeal requests on the Request for Appeal form, available in the provider operations manual on the Health Net provider website at provider.healthnet.com.

Providers must comply with the following to file an appeal:

- The provider who rendered the service must submit the appeal request with all necessary information, including new information that was not originally submitted, documenting the reason for the appeal request, the original claim, EOP, prior authorization letter or form, and supporting medical records to the Health Net Provider Appeals Department
- The reason for the appeal must be clearly stated
- The disputed amount for each claim must be clearly stated

- HMO, Point of Service (POS) and PPO only: Appeal requests must be received by Health Net within 365 days of the date of the EOP unless the *PPA* states otherwise
- MA only: Appeal requests must be received by Health Net within two years for MA claims from the date of the EOP unless the *PPA* states otherwise

Upon receipt of the appeal, the Provider Appeals Department reviews the appeal and approves or denies it within 30 calendar days of receipt of the request based upon the information submitted. If an appeal is denied based on failure to comply with the appeal submission requirements, including those listed above, and timeliness requirements, the underlying claims may be denied. If denied, they are treated as nonreimbursable and cannot be billed to the member.

Interest payments on adjusted claims

Health Net applies interest to adjusted claims in accordance with Arizona Revised Statute (ARS) 20-3102 (I). If a claim is adjusted, Health Net does not owe interest as long as the adjusted payment is made within 30 days of the date the claim was received as a requested claim adjustment.

Appeals submission

Appeals must be submitted by mail to:

Health Net of Arizona, Inc.
Attention: Provider Appeals
PO Box 279378
Sacramento, CA 95827-9378

Specific billing requirements

Allergy tests

If more than 160 tests are performed on a member during a 12-month period, medical review is required. Additional testing requires the submission of documentation to justify the additional testing, including an evaluation of the test results, office notes and a treatment plan.

Anesthesia

The referring physician's name must be in box 17 of the CMS 1500 claim form. For a cesarean section performed after epidural anesthesia, indicate administration time for the general anesthetic and the epidural separately on the claim. The unit field must contain the number of base and time units being charged. The minutes must be noted on the claim form. Ensure all appropriate modifiers are included.

Antigen/allergen injections

Specify the type of injection provided in box 24C of the original CMS 1500 and box 24D of the revised CMS 1500 form. Inhalant, venom and cat antigen are reimbursed. Up to 52 allergen injections are allowed during a rolling 12-month period. Additional injections are subject to medical review.

Assistant surgeon

Include the name of the surgeon in box 19 of the original CMS 1500 claim form and box 17 of the revised CMS 1500 form. Use modifier 80 or 81 for physicians and modifier AS for non-physicians after the applicable CPT-4 code.

Billing by report

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

Injectable medications

List the appropriate HCPCS "J" code identifying the medication name, strength, dosage, and method of administration (intravenous, intramuscular). When a HCPCS code is not available, one of the generic codes (90780, J3490 or J9999) can be billed. The National Drug Code (NDC) or a written description of the medication given, including the strength, dosage and method, must be included on the claim.

Newborn billing

Health Net provides coverage for newborns for the first 31 days, regardless of the member's intent to enroll the newborn. Providers must notify Health Net's Newborn Data Collection Unit at (800) 977-7518 of all newborn admissions. Provide the admitting pediatrician's identification when calling in the notification.

Submit all newborn claims under the newborn member's ID number and include the newborn's name, date of birth and gender on the claim. If the newborn has not yet been assigned a member ID number, the claim is pended until an ID number is assigned. Providers must follow all authorization requirements.

Additional facility claims requirements:

- Bill according to Medicare guidelines, if applicable
- Itemizations are necessary if required to apply stop-loss provisions
- Maternity and newborn claims must be submitted together

Third-party recovery

Members agree at the time of enrollment to assist in the collection or recovery of monies owed by other parties. These cases may include workers' compensation, auto accidents and other injuries or illnesses for which another party may be found liable and recovery may be permitted under law. In these cases the following billing requirements apply:

- *Workers' compensation*
  Bill the employer's industrial insurance carrier first when responsibility has been established. Health Net pays for claims denied by the employer's industrial insurance carrier if all the following occurs:
  - A copy of the denial is sent with the claim to Health Net
  - All Health Net authorization requirements have been met
  - The service provided is a covered benefit under the member's benefit plan

Pending cases

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

Coordination of benefits

Coordination of benefits (COB) occurs when a member is covered by two or more employer group health insurance plans. Most group health plans contain a provision stating that when a member is covered by two or more group health plans, payment is divided between them so that the combined coverage pays up to 100 percent of eligible expenses, as defined by each payer.

COB allows group health plans to eliminate the opportunity for a person to profit from an illness or injury as the result of duplicate group health plan coverage. Generally, one plan is determined to be primary, and that plan pays without regard to the other. The secondary plan then makes only a supplemental payment that results in a total payment of not more than the eligible expenses, as defined by each payer, for the medical service provided.

If one plan is an individual plan, not a group plan, both plans pay as primary. The payments do not coordinate.

Participating providers are required to administer COB when such provisions are a requirement of the benefit plans. The participating provider should ask the member for possible coverage through another group health plan and enter the other health insurance information on the claim.

Health Net entitlements

Health Net is entitled to:

- Determine whether and to what extent a member is entitled to services or benefits under a payer other than Health Net for covered services under the *EOC*
- Establish in accordance with the priorities for determining primary responsibility among the payers obligated to provide services or indemnity
- Release to or obtain from any other payer information needed to implement coordination of benefits
- Recover the value of covered services rendered to the member to the extent that they are actually provided or indemnified by another payer

Providing COB information (HMO, POS and PPO only)

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

- Name of the other carrier
- Subscriber ID number with the other carrier

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

- Determine which carrier is primary using the guidelines listed in the following Determination of Primary Coverage section
- If Health Net is the primary carrier, submit the claim to Health Net

- If Health Net is the secondary carrier, file the claim with the primary carrier first
- After the primary carrier has paid, attach a copy of the EOP or Explanation of Benefits (EOB) to a copy of the claim and submit both to Health Net

Claims submitted to Health Net for secondary payment must be submitted within 60 days of payment from primary carrier's EOP payment or denial. Claims submitted after 60 days are denied for timely filing. If denied on the basis of timeliness, the claims are treated as non-reimbursable and cannot be billed to the member.

Determination of primary coverage

The following order of benefit determination rules are designed to assist in determining primary coverage:

1. If one plan has a COB provision and another plan does not have a COB provision, the plan without the COB provision pays as primary.
2. In the event there are two or more plans covering the same individual, the order of benefit determination is the first of the following rules, that applies:
   - The plan that covers the individual as a subscriber
   - The plan that covers the individual as a dependent
   - Parents of a dependent child are not separated or divorced. If a dependent child is covered under two or more plans, primary responsibility and the order of determination is:
     - The plan of the parent whose birthday falls earlier in a calendar year
     - If both parents have the same birthday, the plan that covered the parent longer
     - The term birthday, as used in this provision, refers only to the month and day in a calendar year, not the year in which the person was born
   - Parents of a dependent child are separated, divorced or living separately. If a dependent child is covered under two or more plans, primary responsibility and the order of benefit determination is:
     - If the specific terms of a court order state that one parent is responsible for the health care benefits of such child, and the plan entity who is obligated to pay or provide expenses for the plan of that parent has actual knowledge of the court order, then the benefits of that plan are determined first. This does not apply with respect to any claim determination period or year during which any benefits are actually paid or provided before the entity has that actual knowledge
     - If there is no court order or the court order does not specify that one parent is responsible for health care benefits:
       - The plan of the parent having custody of the child
       - The plan of the spouse of the parent having custody of the child
       - The plan of the parent not having custody of the child
   - Parents of a dependent child are separated, divorced or never married and have joint custody of the child. If the specific terms of a court order state that the parents have joint custody of the child, without specifying which parent has responsibility for the child's health care expenses, benefits are determined on the same basis as for a child whose parents are not separated or divorced
   - If one of the other plans is issued outside the state of Arizona and has rules based upon the gender of the parent, and not the birthday rule as described above, and as a result the plans do not agree on the order of benefits, then the gender rule as described above prevails. Otherwise, the birthday rule prevails

3. Active/inactive employee. The benefits of a plan that covers a person as an employee (or as that employee's dependent) are determined before those of a plan, which covers that person as a laid-off or retired employee (or as that employee's covered service). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
4. Continuation coverage. If an individual is covered under a continuation plan as a result of the purchase of coverage as provided under federal or state law, and also under another group plan, the following is the order of benefit determination:
   - First, the benefits of a plan covering the person as an employee (or as that employee's dependent)
   - Second, the benefits of coverage purchased under the continuation plan. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored
5. Longer/shorter length of coverage. If none of the above rules determine the order of benefits, the benefits of the plan that covered the member longer are determined before those of the plan, which covered that person for the shorter term.

When coordinating with Consolidated Omnibus Budget Reconciliation Act (COBRA), Medicare is primary over COBRA.

COB payment calculations

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

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

If a participating provider contracts with two HMOs and the member belongs to both, the member must comply with all prior authorization requirements for both carriers in order to coordinate benefits. For example, if the primary carrier, as well as Health Net, requires authorization for a procedure or service, and authorization is requested and approved by the primary carrier, Health Net does not require authorization for that procedure or service. However, if the primary carrier requires authorization and authorization is not requested or approved from the primary carrier, and Health Net requires authorization, Health Net does not make payment as the secondary carrier unless the prior authorization is requested and approved by Health Net.

Coordination with Medicare

Medicare is the secondary payer when the following conditions exist:

- If the member is age 65 or older, has health insurance coverage under an employer group plan with 20 or more employees, and coverage is based on the member's own current employment or the current employment of a spouse of any age
- If the member is under age 65, entitled to Medicare on the basis of disability, has health insurance coverage under a large group health plan (includes at least one employer with 100 employees) by virtue of member's own employment or the current employment of a family member
- For the first 30 months of end-stage renal disease (ESRD)-based Medicare eligibility or entitlement, if the member has ESRD and is covered by an employer group health plan regardless of the number of employees in the group or current employment status

- If the member has any no-fault insurance, including automobile, medical and non-automobile no-fault insurance
- If the member has any liability insurance, such as automobile liability insurance and malpractice insurance
- If the member has any workers' compensation plans

Coordination with other government payers

Health Net is primary for any payer that is a government plan and for which federal or state law requires Health Net to be the primary plan.

Accept assignment

By law, Health Net may only pay providers who accept assignment up to the Medicare allowable amount; however, the amount paid cannot exceed the contracting Health Net allowable amount.

Do not accept assignment

Health Net may pay providers who do not accept assignment up to the Medicare limiting charges; however, the amount paid cannot exceed the Health Net allowable amount.

Overpayments

Health Net makes every attempt to identify a claim overpayment and issues a notice requesting reimbursement of an overpayment (Overpayment Refund Request) from the provider within 30 days of the overpayment being identified. If a provider receives an Overpayment Refund Request from Health Net, the provider should follow the instructions outlined in the letter for returning the overpayment or disputing the request. An automatic system offset, where applicable, might occur in accordance with the terms outlined in the Overpayment Refund Request once the appropriate notification period has passed.

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

- Send a check made payable to the appropriate entity (Health Net of Arizona or Health Net Life Insurance Company)
- Include a copy of the remittance advice (RA) that accompanied the overpayment to expedite Health Net's adjustment of the provider's account. If the RA is not available, the following information must be provided: Health Net member name, date of service, payment amount, Health Net member ID number, vendor name, provider tax ID number, provider number, vendor number, and reason for the overpayment refund. If the RA is not available, it takes longer for Health Net to process the overpayment refund
- Send the overpayment refund and applicable details to:

  Health Net Overpayment Recovery Department
  Health Net of Arizona Claims Refunds
  File # 749801
  Los Angeles, CA 90074-9801

If a provider is contacted by a third-party overpayment recovery vendor acting on behalf of Health Net, such as AIM, Rawlings, GB Collects, or ORS, the provider should follow the overpayment refund instructions provided by the vendor.

If a provider believes he or she has received a Health Net check in error and has not cashed the check, he or she should return the check to the Health Net Overpayment Recovery Department with the applicable RA and a cover letter indicating why the check is being returned.

Additional information

Contact the Customer Contact Center at (800) 289-2818 with questions regarding third-party recovery, coordination of benefits or overpayments.

Complete billing information is available through a Health Net provider relations representative or on the Health Net provider website at provider.healthnet.com.

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POLICIES AND PROCEDURES

Overview

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

Complete policy and procedure information is available through a Health Net provider relations representative or on the Health Net provider website at provider.healthnet.com.

Office hours and equipment

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

Appointment accessibility standards*

Type of access	Guidelines
REGULAR AND ROUTINE (NON-URGENT SYMPTOMATIC) CARE APPOINTMENTS	Appointments with a primary care physician (PCP) or designated alternate for routine primary care visits must be within 15 days
URGENT CARE VISITS	Appointments with a PCP or designated alternate for urgent care visits must be within 24 hours of the request
AFTER-HOURS CARE	Member must have the ability to contact the on-call physician after hours. After-hours emergency instructions must be available
SPECIALTY CARE	Appointments with a specialist must be within 60 days of member's request or sooner if medically necessary
ROUTINE HEALTH ASSESSMENT (ASYMPTOMATIC) OR PREVENTIVE HEALTH CARE	Appointments must be within 60 days of member's request or sooner if medically necessary

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

Balance billing

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

Choosing a covering and collaborating physician

Health Net physicians who utilize other physicians to cover their practices while on vacation or leave of absence must make their best efforts to find a Health Net participating physician within the same specialty. If a Health Net participating physician is unable to cover the practice, the following must occur:

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

Providers may request approval for the use of a nonparticipating, covering physician by contacting Health Net's Provider Network Management Department.

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

Hospitalists

Health Net contracts with several hospitalist service providers. Participating hospitalists must be used whenever hospitalist services are required, or the Health Net member's PCP or specialist may admit the member, as necessary. For assistance locating a participating hospitalist, contact the admitting facility directly or the Health Net Provider Services Center during normal business hours at (800) 289-2818.

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

- Admission and discharge dates
- Presenting problem
- Discharge diagnoses
- Discharge medications
- Follow-up instructions

Refer to the Health Net Discharge Summary Form, available online in the Health Net provider operations manuals at provider.healthnet.com, or incorporate these standards into the form currently used.

PCP closure

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

If a patient of the PCP, while a member of another health care plan, joins Health Net, the PCP must continue to accept the member as a patient even if his or her practice is closed to new Health Net members.

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

Noncompliant members

Identification of noncompliance

To identify a member as noncompliant:

- Document all areas of noncompliance, for example, missed appointments or failure to follow the physician's treatment plan
- Notify the member and the Health Net customer service manager in writing of the potential dismissal of care due to continued noncompliance, and give the member at least 30 days to become compliant to avoid dismissal

Termination of physician-patient relationship

If the member fails to become compliant, notify the member via certified mail that the relationship is terminated and include the reason for the termination. The letter must advise the member of his or her right to transfer records to a new physician or to pick up the records in order to hand-deliver them to the new physician. The physician must also notify the member that the physician continues to be available for urgent or emergency care for the following 30 days. By the end of the 30 days, the member should have arranged for a new physician. Providers must place a copy of the member letter in the member's medical record and send a copy to the Health Net customer service manager via secure fax or mail as follows:

Fax: (800) 204-3778 (Attn: Customer Service Manager)
Health Net of Arizona
Customer Service Manager
PO Box 276090
Sacramento, CA 95827-6090

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PRIOR AUTHORIZATION PROCEDURES

Referrals

HMO, POS and Medicare Advantage

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

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

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

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

PPO

PPO members may self-refer to any licensed physician; however, benefit levels are determined by whether members use Health Net PPO in-network providers. Members using out-of-network providers may have reduced benefits and higher out-of-pocket costs.

Prior authorization

Prior authorization is the process by which Health Net or a delegated medical group/IPA determines whether a requested medical service meets the criteria of medical necessity.

Requests for prior authorization are reviewed based on a member's benefit coverage and whether the medical information received meets national medical criteria. All other coverage requirements must also be met in order for a claim to be eligible for payment.

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

All prior authorization procedures must meet Health Net turnaround standards, regardless of delegation status. Upon receipt of all necessary information (or when the prior authorization request is received for Medicare Advantage (MA)), Health Net or its delegated entity processes all standard, routine requests within:

- 14 calendar days for MA
- 10 business days for all other lines of business

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

HMO

Providers are responsible for obtaining prior authorization; the member must not be billed if the provider fails to obtain prior authorization before performing services. When Health Net is the member's secondary coverage, no prior authorization is required.

PPO

The PPO member is responsible for requesting prior authorization. Physicians are able to request prior authorization on behalf of a member and are encouraged to do so, but the responsibility belongs to the member. Members can be held financially responsible for services rendered without prior authorization. When Health Net is the member's secondary coverage, no prior authorization is required.

Prior authorization process

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

Health Net uses InterQual® Criteria Sets, Hayes Medical Technology Directory, and National Medical Director Advisory Board Statements to assess appropriate levels of care and service. Health Net uses the Centers for Medicare and Medicaid Services (CMS) National Coverage Decisions (NCD) and Local Coverage Determinations (LCD), which are written decisions of carriers and intermediaries in the geographic area for services that are covered for members in an MA plan.

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

Medical directors are always available to discuss prior authorization requests and denials with the requesting physician by contacting the Prior Authorization Department. The denial letter includes criteria used in a decision that results in a denial determination and an explanation of the appeal process. A copy of the criteria utilized in the decision can be obtained upon request.

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

Obtaining prior authorization

Routine and urgent requests

Requests for prior authorization for services that are provided by non-delegated participating providers must be directed to the Health Net Prior Authorization Department. Providers should be prepared to provide all information pertaining to the treatment plan, including diagnosis and procedure codes.

Expedited initial determinations (MA only)

An expedited initial determination is a request for an expedited review of an authorization request for services. An expedited initial determination is available if the standard time frame for issuing a determination could jeopardize the life or health of the member or member's ability to regain maximum function.

Expedited initial determinations are reviewed and resolved as expeditiously as the member's health requires, but no later than 72 hours. Providers should contact the Health Net Prior Authorization Department at (800) 977-7518 to request an expedited initial determination and clearly state that the request is expedited.

Members may also request an expedited initial determination by calling the Health Net Medicare Programs Department at (800) 977-7522.

Health Net reviews the case to ensure it qualifies for expedited processing.

Emergencies

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

Emergency services are covered both in-network and out-of-network and do not require prior authorization. In accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA), emergency room (ER) screening and stabilization services do not require prior approval to be covered by Health Net.

Prior authorization responses

The requesting physician is responsible for communicating with his or her patient when Health Net approves requests for authorizations. Physicians who are notifying MA members (orally or in writing) regarding favorable determinations must document and track these responses for audit purposes. Health Net is also required to notify MA members of prior authorization determinations.

In the event the request fails to meet established criteria and is denied, a letter is automatically sent to the member, the requesting physician, and the PCP, if applicable. The letter includes an explanation of the appeal process and how a member or applicable provider can obtain a copy of the criteria utilized in

the decision. The physician may discuss the case with a medical management reviewer or physician reviewer by contacting the Health Net Prior Authorization Department at (800) 977-7518.

Health Net must notify MA members regarding adverse expedited determinations within 72 hours, so the member receives the notice by the 72nd hour, if notified in writing. If members are notified orally regarding adverse expedited determinations, written notice must be mailed within three calendar days of the oral notice.

Prior authorization requirements

The most current services, procedures and equipment requiring prior authorization for Health Net members are available on Health Net's provider website at provider.healthnet.com. Select *Working with Health Net > Contractual > Services Requiring Prior Authorization.*

Select radiology and cardiology imaging services

The following imaging services require prior authorization through MedSolutions®, Inc. Providers should call (888) 693-3211 to request:

- Computed tomography (CT) and positron emission tomography (PET) scans
- Magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA)
- Nuclear cardiac imaging procedures
- Stress echocardiography
- Transesophageal echocardiography
- Transthoracic echocardiography

Authorization may be approved only when services are rendered at a MedSolutions registered facility.

Behavioral health

Behavioral health services require prior authorization. Providers should call MHN at (800) 977-0281.

Nonparticipating providers

Care provided by a nonparticipating physician or facility requires prior authorization with one exception. PPO and Point of Service (POS) plan members are not required to obtain prior authorization for care received out-of-network or by nonparticipating providers.

Notification of admissions

All elective, urgent and emergency inpatient, and skilled nursing facility (SNF) admissions must be reported to Health Net's Prior Authorization Department within 24 hours or the next business day, unless otherwise stated in the *Provider Participation Agreement (PPA).*

Notify Health Net of a newborn, inpatient or SNF admission by contacting the Prior Authorization Department at (800) 978-3424 within 24 hours of admission or the next business day. Services denied for late or non-notification are considered nonreimbursable and may not be billed to the member.

Required information

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

- Facility name
- Name of caller reporting admission
- Telephone number of caller reporting admission
- Member's full name
- Member's Health Net ID
- Member's date of birth
- Admission date
- Admission time
- Room number (for ER notifications there may not be a room number assigned)
- Admit type (how member arrived at inpatient stay – elective, direct, urgent, emergent)
- Admitting diagnosis or chief complaint
- Type of admission (medical, surgical, telemetry, or intensive care)
- Admitting or attending physician (ER physicians cannot be identified as they are not going to follow the patient during their facility stay. When notifying Health Net of a newborn admission, identify the admitting pediatrician)
- Other insurance if Health Net is not primary carrier
- Status of admission (inpatient, skilled nursing, or sub-acute rehabilitation)

Process

When Health Net is notified of hospital admissions, the prior authorization staff verifies eligibility, hospitalist or PCP assignment and whether the service requires prior authorization. Health Net enters the notification into the system to generate a case tracking number and issues the number to the caller. If Health Net's systems are unavailable, a temporary tracking number is assigned.

The facility is responsible for obtaining the permanent tracking number by contacting Health Net prior to claim submission.

All elective urgent and emergency inpatient and SNF admissions must be reported to Health Net's Prior Authorization Department within 24 hours or the next business day, unless otherwise stated in the facility contract.

Providers should not call or report ER treat and release, elective outpatient or observation care to Health Net unless the stay moves to a full inpatient admission.

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

Questions

Providers who have questions regarding prior authorization may contact the Health Net Prior Authorization Department, 24 hours a day, seven days a week, at (800) 978-3424 for assistance.

Comprehensive prior authorization information is available through the provider relations representative or in the provider operations manuals available on the Health Net provider website at provider.healthnet.com.

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QUICK REFERENCE

Table 3: Telephone Listing

Name	Contact Numbers
COMMERCIAL APPEALS AND GRIEVANCES (MEMBER)	Fax: (800) 977-6762
CUSTOMER SERVICE • Eligibility • Claims • Benefit verification • Third-party recovery • Coordination of benefits • Refunds • Appeals and grievances (member)	(800) 289-2818
DECISION POWER®	(800) 893-5597
HEALTH NET PHARMACEUTICAL SERVICES	(800) 410-6565 Fax: (800) 977-4170
MEDICARE ADVANTAGE (MEMBER)	(800) 977-7522
MEDSOLUTIONS®	(888) 693-3211 Fax: (888) 693-3210
MHN (BEHAVIORAL HEALTH SERVICES)	(800) 977-0281 (authorization and triage)
NOTIFICATION OF ADMISSIONS	(800) 978-3424 (available 24/7)
PREFERRED HOME CARE	(800) 636-2123
PRIOR AUTHORIZATION	(800) 977-7518 (central intake)
THIRD-PARTY RECOVERY, COORDINATION OF BENEFITS AND REFUNDS	(800) 289-2818

Table 4: Important Addresses	
Function	Addresses
CLAIMS APPEALS	Health Net of Arizona Attention: Provider Appeals PO Box 279378 Sacramento, CA 95827-9378
CLAIMS RECOVERY/REFUNDS	Health Net Overpayment Recovery Department Health Net of Arizona Claims Refunds File # 749801 Los Angeles, CA 90074-9801
COMMERCIAL APPEALS AND GRIEVANCES (MEMBER)	Health Net of Arizona Commercial Appeals and Grievances Department Attn: Appeals and Grievances Manager PO Box 277610 Sacramento, CA 95827 Fax: (800) 977-6762
HEALTH NET OFFICES	Northern Region/Corporate Office: Health Net of Arizona 1230 W. Washington St. #401 Tempe, AZ 85281 Southern Region Office: Health Net of Arizona 5255 E. Williams Circle #4000 Tucson, AZ 85711
HEALTH NET PROVIDER WEBSITE	provider.healthnet.com
MEDICARE ADVANTAGE APPEALS AND GRIEVANCES (MEMBER)	Health Net of Arizona Medicare Advantage Appeals and Grievances Department PO Box 279410 Sacramento, CA 95827-9377 Fax: (800) 977-6855 Fax: (800) 805-1542 for expedited appeals requests
PAPER CLAIMS	ACS/Health Net of Arizona – Commercial PO Box 14225 Lexington, KY 4012-4225 ACS/Health Net of Arizona – Medicare PO Box 14730 Lexington, KY 40512-4225

For more information, please contact:

Health Net of Arizona
1230 W. Washington Street, Ste. 401
Tempe, AZ 85281

5255 E. Williams Circle #4000
Tucson, AZ 85711

13-216
6028651