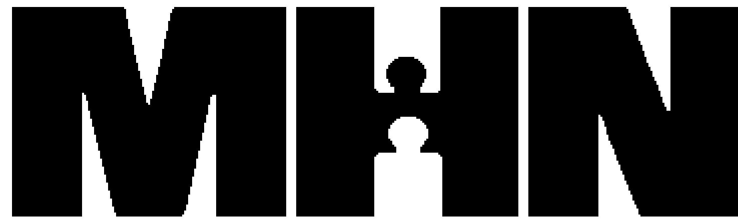

Managed Health Network

Practitioner Manual
Cal MediConnect
2014

Provider Manual

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SECTION 1
OVERVIEW OF DEMONSTRATION PROJECT AND MODEL OF CARE

In April of 2012, the California Department of Health Care Services (DHCS), in partnership with the Centers for Medicare and Medicaid Services (CMS), selected Health Net, MHN's parent company, to participate in the Cal MediConnect demonstration, also known as Cal MediConnect in Los Angeles and San Diego counties. This three-year demonstration promotes coordinated health care delivery for beneficiaries who are eligible for both Medicare and Medi-Cal (Dual Eligibles). The goal of the demonstration is patient centered care with an emphasis on improving access to care, coordination of services and increasing the availability and access to home and community-based services.

The services covered under this demonstration include, but are not limited to: Long-term support services, including in-home supportive services (IHSS), Community-Based Adult Services (CBAS), long-term custodial care in nursing facilities, and Multipurpose Senior Services Program (MSSP) services. Mental health and substance abuse programs as well as outpatient mental health services are also included. As Health Net's behavioral health subsidiary, MHN administers the Medicare covered behavioral health and substance abuse services for Cal MediConnect enrollees in Los Angeles and San Diego Counties.

DIVISION OF RESPONSIBILITY

The following is a breakdown of the division of responsibility between MHN and county agencies under the Cal MediConnect Program.

	MHN Responsibility **Medicare Covered Services such as:**	**County Mental Health Responsibility** **Specialty Mental Health Services NOT covered by Medicare such as:**
Psychiatric	Psychiatric Inpatient (including ER)	Rehabilitative mental health services:
	Psych Services in a Skilled Nursing Facility	Crisis intervention
	Psychiatric Outpatient Services	Crisis stabilization
	Medication Eval and Management Sessions	Crisis residential
		Club houses
Substance Abuse	**Alcohol and Drug Services such as:**	**Drug Medi-Cal Services such as:**
	Inpatient detoxification	Day care rehabilitation
	Outpatient treatment by licensed clinician	Outpatient individual and group counseling
	Naltrexone (Vivitrol) treatment	Methadone maintenance therapy

CAL MEDICONNECT'S MODEL OF CARE

Health Net and MHN collaboratively participate in the following Model of Care for Cal MediConnect enrollees. The goals for the Cal MediConnect Model of Care, as stated by CMS and DHCS, are to improve outcomes through:

- Improving access to essential services such as medical, mental health, long term supportive services (LTSS), and social services.
- Improving access to affordable care by optimizing utilization of home and community based services (HCBS).
- Improving coordination of care through an identified point of contact and medical home.
- Improving seamless transitions of care across health care settings, providers and HCBS.
- Improving access to preventive health services.
- Improving access to HCBS/LTSS.
- Assuring appropriate utilization of services.
- Improving enrollee health outcomes and satisfaction.
- Preserving and enhancing the ability of consumers to self-direct their care and enable Cal MediConnect enrollees to remain in their homes and communities.

For detailed information on the Cal MediConnect Model of Care, you may visit MHN's provider portal and view our PowerPoint presentation on "Model of Care".

SECTION 2
IMPORTANT PHONE NUMBERS & ADDRESSES

2.1 TELEPHONE DIRECTORY

Intake, Care Management Access Lines
(855) 464-3571 - Duals L.A.
(855) 464-3572 - Duals San Diego
(888) 788-5654 - TTY MHN

Professional Relations Customer Service
(800) 541-3353
9AM –1 PM Central

MHN Customer Service
(800) 444-4281
8 AM-7 PM Central

Enrollee Complaints
(855) 464-3571 - Duals L.A.
(855) 464-3572 - Duals San Diego
(888) 788-5654 - TTY MHN

Provider Complaints
Email Professional_Relations@mhn.com

2.2 IMPORTANT MAILING ADDRESSES

Send all claims forms to:
MHN
P.O. Box 14621
Lexington, KY 40512-4621

Send all credentialing documentation to:
MHN Credentialing
P.O. Box 10086
San Rafael, CA 94912

Appeals, Utilization Management Decisions:
MHN Provider Disputes Unit
P.O. Box 10697
San Rafael, CA 94912

MHN Corporate Office:
MHN
P.O. Box 10697
San Rafael, CA 94912

2.3 MHN's PROVIDER PORTAL

https://www.mhn.com/provider/start.do

SECTION 3
ACCEPTANCE CRITERIA AND CREDENTIALING

Providers in MHN's Cal MediConnect network are selected and credentialed based on established criteria reflecting professional standards for education, training and licensure. Eligible providers include psychiatrists, psychologists, clinical social workers, and clinical nurse specialists who are participating in Medicare. Credentials are verified upon initial application to the network and every three years thereafter, as required by regulatory and accrediting agencies. Information supplied to comply with credentialing requirements cannot be more than 180 days old at the time of Credentialing Committee review.

Initial Credentialing

Physician-level providers must meet the following selection criteria:

1. Graduation from an accredited medical school
2. Current, unrestricted medical license in the state in which practice is to occur

3. Professional liability insurance coverage in the amount of $1 million per occurrence/$3 million aggregate
4. Psychiatrists must have Board certification in psychiatry or completion of an ACGME-accredited residency in psychiatry
5. Current controlled substances registration (DEA certificate)
6. Current resume or curriculum vitae that details five years of relevant work history and clinical training (work absences must be explained by the applicant)
7. Foreign medical school graduates must submit ECFMG certification to demonstrate proficiency in the English language
8. Participation in Medicare
9. Hold a current National Provider Identifier (NPI) number
10. Must be in good standing with Medicare and Medicaid

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

1. Must hold a Masters or Doctorate degree from a professional school
2. Independently licensed in California
3. Current, unrestricted license in California
4. Professional liability insurance in the amount of $1 million per occurrence/$1 million aggregate
5. Current resume or curriculum vitae that details five years of relevant work history and clinical training (work absences must be explained by the applicant)
6. Participation in Medicare
7. Hold a current National Provider Identifier (NPI) number
8. Must be in good standing with Medicare and Medicaid
9. Registered nurses, nurse providers and clinical nurse specialists must have a California license that has language or a designation related to a behavioral health specialty. If the license does not have such language, or such language is not available, then a current ANCC Certification in any of the following certification areas will meet this criteria:
   a. Clinical Specialist in Adult Psychiatric and Mental Health Nursing
   b. Clinical Specialist in Child and Adolescent Psychiatric and Mental Health Nursing
   c. Adult Psychiatric and Mental Health Nurse Provider
   d. Family Psychiatric and Mental Health Nurse Provider

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

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

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

1. A felony conviction or misdemeanor conviction
2. A pending felony allegation or misdemeanor allegation
3. Sanctions by a federal or state payment program (e.g., Medicare, Medicaid, or TRICARE)
4. Adverse professional review actions reported by any professional review board

5. Denial, loss, suspension or limitation of medical license or narcotics license
6. Malpractice claim, investigation or lawsuit filed
7. Cancellation or material modifications of professional liability insurance
8. Physical or mental condition or substance abuse problem which would impair ability to practice

The following credentials are verified through primary sources:

1. Graduation from medical or other professional school appropriate to the state licensing requirement
2. Current, valid license to practice independently
3. Valid, unrestricted DEA or CDS certification, as applicable
4. Board certification, as applicable
5. Malpractice claims payment history from the National Practitioner Data Bank
6. DHHS Medicare/Medicaid Sanctions

Recredentialing

MHN recredentials providers in its network every 36 months. MHN conducts primary or secondary source verification on all credentials in the recredentialing process. Documents can not be more than 180 days old at the time of review.

All applicants for recredentialing must report whether any of the following has occurred:

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

Recredentialing also includes a review of any prior quality issues and enrollee complaint history.

Ongoing monitoring of sanctions

MHN performs ongoing monitoring of Medicare/Medicaid sanctions and exclusions, board sanctions or licensure actions, and enrollee complaint history. When MHN participating providers are identified as being subject to these actions, they are presented, to MHN’s Credentialing Committee for review and appropriate action.

Provider Rights related to Credentialing & Recredentialing

Providers have a right to review information submitted in support of their Credentialing and Recredentialing applications (not including confidential evaluations or other confidential peer review documentation). In addition, if information obtained by MHN during the Credentialing or Recredentialing

process varies substantially from information provided by the provider, MHN will notify the provider in writing of any discrepancy. Providers have a right to correct erroneous information.

All information gathered by MHN in the credentialing and recredentialing process is treated confidentially, except as otherwise provided by law. Credentialing and recredentialing information is available to MHN Credentialing staff, Peer and Quality Reviewers and Credentialing Committee enrollees only on a need-to-know basis.

Providers are sent a written notification within 10 business days of the initial credentialing decision. Thereafter, providers are considered Recredentialed, unless otherwise notified by MHN.

Site Visits

MHN will conduct an Office Site Evaluation when there is a pattern of enrollee complaints related to an office's physical appearance and/or its management. Site Evaluations can also be conducted for quality assurance purposes.

SECTION 4
CONTRACTUAL & REGULATORY REQUIREMENTS

CONTRACTUAL REQUIREMENTS:

The following are some important contractual requirements for network participation in the Cal MediConnect Program. For a listing of all contractual requirements, please see your Participating Provider Agreement with MHN, along with the Addendum Z, the Cal MediConnect Program Addendum.

Compliance with MHN credentialing policies:

MHN's Participating Provider Agreement requires that providers comply with MHN's credentialing processes and policies. Under this agreement, providers must maintain a clear, unrestricted license to practice and notify MHN within 5 days of any of the following:

- Licensing actions
- Malpractice claims or arbitration
- Felony indictments
- Disciplinary actions before a state agency
- Cancellation or material modification of professional liability insurance
- Actions taken to modify participation in federal programs such as TRICARE, Medicare or Medicaid
- Enrollee complaints against provider
- Any situation that would impact the provider's ability to carry out the provisions of the contract

Notice of information change:

MHN collects information regarding provider demographics and clinical specialties, and maintains this information in our provider database. MHN also collects information on handicapped accessibility to

provider offices, and whether providers are available for new referrals. This information is uploaded daily to our online provider directory at www.mhn.com.

Providers must notify MHN, in writing or online or through the Provider Portal at www.mhn.com, at least 90 days prior to any change to their availability or location of covered services. They also must notify MHN of any changes in office hours, tax identification number, bilingual language abilities, professional license number and, if applicable, DEA or CDS registration number.

Providers can update their demographics and/or profile using the Provider Portal on MHN's website, calling the provider line at (800) 541-3353, and/or sending an email to: Professional.Relations@MHN.com.

Participation in Interdisciplinary Care Team (ICT) or Behavioral Health Care Disciplinary Team (BHCDT) meetings:

The Centers for Medicare and Medicaid Services (CMS) model of care specifies that care is coordinated for Cal MediConnect enrollees through an Interdisciplinary Care Team (ICT) to address the enrollee's medical, cognitive, psychosocial, and functional needs. Each Cal MediConnect enrollee is assigned to an ICT comprised of primary, ancillary, and specialty providers. The ICT is responsible for managing the medical, cognitive, psychosocial, and functional needs of enrollees within their individualized care plan. These meetings are led and coordinated by a Health Net or MHN Care Manager. Cal MediConnect enrollees, caregivers and/or family members are also encouraged to participation in the ICT meetings.

The role of the Interdisciplinary Care Team is to:

a) Analyze and incorporate the results of an initial and annual health risk assessment into a care plan.
b) Collaborate to develop an individualized care plan for each enrollee annually and update as health status changes.
c) Manage the medical, cognitive, psychosocial, and functional needs of the enrollees.
d) Communicate to team enrollees and providers of care to coordinate the enrollee care plans.
e) Participate in the enrollee's care plan development and care coordination, as needed.

Every Cal MediConnect enrollee will have an ICT, and those with specific behavioral health needs will also have a Behavioral Health Care Disciplinary Team (BHCDT). The BHCDT provides care management and coordination for behavioral health services specifically. The BHCMT can be comprised of the mental health provider(s), the MHN case manager, a representative from the county mental health plan, the enrollee, and any family members or caregivers. A member of the BHCDT will serve as the behavioral health liaison to the ICT.

As a condition of participation in this program, MHN providers are required to participate in these meetings as needed via phone. The frequency of team meetings will be determined based on the enrollee's needs, based on complexity and acuity of the enrollee's needs. Meeting frequency can range from once annually for stable, self-directed individuals, to daily interaction during an acute episode or transitional care process. Care plans are reviewed annually, at minimum, and when the enrollee's status changes or there is a care transition. A Care Manager will coordinate the team activities to review care plans and progress towards meeting goals.

Coordination with the County Mental Health Plans who may provide Medi-Cal specialty mental health and alcohol drug services:

Cal MediConnect enrollees who have been assessed to need specialty mental health services and/or alcohol drug services and related specialty consultations will be referred to the County Mental Health Plans. These referrals may include enrollee self-referral, PCP, and/or referrals from other ICDT members, based on evaluation of the enrollee's medical and psychosocial history, current state of health, and request for services by enrollee or enrollee's family. ***Therefore MHN participating providers are expected to assist with referrals to the County Mental Health Plans as necessary and as determined by the ICDT.***

Education for Cal MediConnect Enrollees:

Per Cal MediConnect program regulations, providers are expected to make health education materials and programs available to Cal MediConnect enrollees on the same basis that it makes such materials and programs available to the general public, and should use their best efforts to encourage Cal MediConnect enrollees to participate in such health education programs.

Compliance with MHN's Language Assistance Program (LAP):

Providers must comply with MHN's ongoing language assistance program to ensure Limited English Proficient ("LEP") Cal MediConnect enrollees have appropriate access to language assistance, including sign language support, while accessing services.

MHN created the Language Assistance Program (LAP) to ensure that LEP enrollees are able to obtain language assistance while accessing mental health care services. MHN provides enrollees with language assistance through face-to-face, telephonic, and written interpretation services as well as through our diverse network of practitioners. Interpretation services are arranged by MHN prior to referral to a practitioner to support MHN enrollees' linguistic and cultural needs. MHN maintains ongoing administrative and financial responsibility for implementing and operating the language assistance program for enrollees and does not delegate its obligations under language assistance regulations to its participating providers.

If a provider discovers that an enrollee needs interpretation services after beginning treatment, the provider should contact MHN immediately so that MHN can assist in obtaining the necessary resources. To access these services for Cal MediConnect enrollees, providers can call the toll free number located on the back of the enrollee's identification card.

MHN's Language Assistance Program includes the following:

- Interpreter services for LEP MHN enrollees are available 24 hours a day, seven days a week at all points of contact, by contacting MHN Translation Services at (888) 426-0023. This assistance includes face-to-face, telephonic and written translation services.

- MHN offers a notice of translation services (available in Spanish and Chinese) for vital documents to all California enrollees. This notice is also available to contracted providers for distribution to enrollees upon request.

Provider LAP Compliance Requirements:

All MHN providers are required to support the LAP by complying with the following:

Interpreter Services – Use qualified interpreters for LEP enrollees. Interpreter services are provided by MHN at no cost to the provider or the enrollee. Providers may contact the MHN Translation Services Line or MHN Customer Service to arrange translation services.

Enrollee Complaint/Grievance Forms – Cal MediConnect enrollees wishing to file a grievance or complaint should call the number listed on the back of their identification card, or access **www.mhn.com** to obtain complaint/grievance forms, also available in Spanish or Chinese (links to printable format also provided).

Independent Medical Review Application – Locate the DMHC's Independent Medical Review (IMR) application and provide it to enrollees upon request. This application is available in English, Chinese and Spanish on the DMHC Web site at **www.hmohelp.ca.gov/dmhc_consumer/pc/pc_imrapp.aspx**.

Documentation of language preference- Document the enrollee's language preference and the refusal or use of interpreter services in the enrollee's medical record. MHN strongly discourages the use of family, friends or minors as interpreters. If, after being informed of the availability of interpreter services, the enrollee prefers to use family, friends or minors as interpreters, the provider must document this in the enrollee's medical record.

Telephonic referral if face-to-face assistance goes beyond 15 minute wait time – If a scheduled face-to-face interpreter fails to attend appointment within fifteen minutes of the start of the appointment; providers are encouraged to offer the patient the choice of using a telephonic interpreter. Providers can call MHN Customer Service and a customer service agent will conference in the telephone interpreter to expedite services.

Notify MHN of Language capability changes - Practitioners are contractually obligated to notify MHN of any change to their practice, including changes in language abilities, 30 days prior to the effective date of such a change, by attesting to these changes via the Provider Portal at www.mhn.com. MHN does not track bilingual changes among office staff; however practitioners must notify us when there has been an addition/departure of a bilingual clinician from a group practice.

Cultural Competency Training for Cal MediConnect Enrollees:

Provider must participate in cultural competency training, and provide cultural competency training for all of their staff and group providers who interact with and/or provide Covered Services to Cal MediConnect enrollees. This training must occur within one (1) year of joining MHN's network.

There are several ways to obtain training. Some of which are referenced below.

The United States Department of Health and Human Services' Office of Minority Health (OMH) offers a free computer-based training program on cultural competency for health care providers. This program was developed to furnish providers with competencies enabling them to better treat California's increasingly diverse population. This no-cost educational program is available to providers through the OMH Think

Cultural Health website at www.thinkculturalhealth.org. Health Net does not sponsor or maintain the OMH's training or website.

The OMH Think Cultural Health website at www.thinkculturalhealth.org contains a variety of self-assessments, case studies, video vignettes, learning points, 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.

The Professional Education Services Group (PESG) designates the OMH cultural competency educational activity for a maximum of nine category-one credits toward the American Medical Association (AMA) Physician's Recognition Award. Additional CME information may be found on the OMH Think Cultural Health website at www.thinkculturalhealth.org.

Providers can register online at www.thinkculturalhealth.org 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 the provider logs on to the site, he or she is directed to the page where he or she left off on the previous visit.

MHN has also posted the following PowerPoint presentation on our provider portal: ***Cultural Competency Training for Healthcare Providers: Connecting with your Patients***, as well as the ICE Toolkit – ***Better Communication, Better Care: Provider Tools to Care for Diverse Populations***. Reviewing and attesting that you have read both documents will meet the Cultural Competency training requirements.

For all questions regarding language assistance and cultural competency, contact Health Net's Cultural and Linguistic Services Department at: 1 (800) 977-6750.

Confidentiality Standards:

MHN expects that mental health providers maintain client confidentiality under applicable state and federal laws as applicable to client/therapist privilege, mandated child and elder abuse reporting requirements, and disclosure of records.

Following are MHN Standards for handling of confidential information at provider office sites:

- Providers should release treatment records only in accordance with a court order, subpoena, or statute.
- Providers should assure that any such request for records be legally obtained.
- Provider office staff should be trained regarding the necessity for signed authorization for release of information prior to any disclosure of confidential information, aside from exceptions specified in state and federal laws.
- Providers should limit access to treatment records.
- Providers should have a policy/procedure for:
    - Assuring confidentiality where records are stored electronically
    - Assuring confidentiality where records are transmitted electronically
    - Assuring confidential transmission of patient information by facsimile

- Assuring confidentiality of records delivered through mail or delivery services

- Provider office staff should sign a confidentiality agreement, which should be kept on file in the provider's office.
- Treatment records must be locked when not in use. Treatment record storage locations must be secure and accessed only by approved personnel.
- Purging of treatment records must be done according to state statute, and in a manner, which maintains client confidentiality.

MHN informs enrollees that information shared with MHN staff or network clinicians is confidential. MHN will not disclose enrollee records or information concerning services, and will not disclose the fact that an enrollee accessed MHN services without written consent or unless otherwise required or permitted by law.

Facility Providers only:

Availability of Working Space:

Facilities must provide, upon request, MHN staff, or its designee, appropriate and adequate working space within their facilities.

Lab results:

Facilities must ensure that all Cal MediConnect enrollees' lab results from facility owned and/or facility contracted laboratories are submitted to MHN within thirty (30) days of the date of service and in a mutually agreed upon format. The specific lab results must include, but are not limited to, those tests required for all state and CMS mandated Cal MediConnect enrollees as required and shall be updated annually based on regulatory changes.

Discharge planning:

Facilities must implement comprehensive discharge planning processes to ensure the timely and appropriate level of care is delivered in order to reduce the instances of Cal MediConnect readmissions. Such process requirements are outlined in MHN Policies.

REGULATORY OBLIGATIONS:

The following are the regulatory requirements under the Cal MediConnect Program.

Provider agrees and Provider shall require its subcontractors to agree to the following:

(a) For a period of ten (10) years from the final date of the contract period or the date of any audit, whichever is later, allow HHS, CMS, the Comptroller General, Department of Managed Health Care ("DMHC"), or their designees the right to audit, evaluate, and inspect any books, contracts, records, computer or other electronic systems, including medical records and documentation of Provider and any Provider subcontractor, involving transactions related to Health Net's contract with CMS and DHCS. When such entities request Provider's records, Provider shall produce copies of the requested records at no charge. Provider shall permit Health Net or MHN, and its designated representatives, and designated

representatives of local, state, and federal regulatory agencies having jurisdiction over Health Net, to conduct site evaluations and inspections of Provider's offices and service locations.

(b) Cooperate in, assist in, and provide information as requested for audits, evaluations and inspections performed under (a) above

(c) Safeguard each Cal MediConnect Beneficiary's privacy and comply with the confidentiality and Cal MediConnect Beneficiary record accuracy requirements, including: 1) abiding by all Federal and state laws regarding confidentiality and disclosure of medical records , or other health and enrollment information, 2) ensuring that medical information is released only in accordance with applicable Federal or state law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by Cal MediConnect Beneficiaries to the records and information that pertain to them.

(d) Contracts or other written agreements between Provider and Provider subcontractors must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties.

(e) Hold each Cal MediConnect Beneficiary and the State harmless for payment of any fees that are the legal obligation of Health Net/MHN in the event of, but not limited to, insolvency of, breach by or billing of Provider by Health Net/MHN. This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Cal MediConnect Beneficiaries or persons acting on their behalf.

(f) Comply with all applicable Medicare laws, regulations, reporting requirements and CMS instructions.

(g) Perform each service or other activity in a manner consistent and in compliance with Health Net's contractual obligations to CMS and DHCS.

(h) Maintain all records for a minimum of ten (10) years from the final date of the contract period or the date of the completion date of any audit, whichever is later.

(i) Health Net oversees and is ultimately responsible to CMS and DHCS for any functions and responsibilities described in the Medicare Advantage regulations. Provider understands that this accountability provision also applies to the Cal MediConnect contract between Provider and Health Net/MHN.

(j) Comply with MHN and Health Net Policies.

(k) Not impose or collect cost sharing from any Cal MediConnect Beneficiary that exceeds the amount of cost sharing that would be permitted under Title XIX of the Social Security Act if the Cal MediConnect Beneficiary were not enrolled in the Cal MediConnect Demonstration Program. In no event shall Provider or a Provider subcontractor hold a Cal MediConnect Beneficiary responsible for Medicare Part A or Part B cost sharing for Covered Services when a state entity is responsible for paying such amount under the Medicaid program (includes Medi-Cal). Where the state is responsible for paying the

cost share amount, Provider shall either accept Health Net/MHN's contracted rate as payment in full or bill the appropriate state source for the cost share amount. Health Net/MHN shall inform Provider, and Provider shall subsequently inform Provider subcontractors, of Medicare and Medicaid (Medi-Cal) benefits and rules for Cal MediConnect Beneficiaries.

Provider and Health Net/MHN agree to the following:

(a) Provider shall bill and Health Net/MHN shall make payment for Covered Services in accordance with the rates outlined in the Participating Provider Agreement between Provider and MHN, as well as under Health Net/MHN Policies.

Provider and its subcontractors further agree to the following:

(a) To pay for emergency and urgently needed services consistent with federal regulations, if such services are Provider's liability.

(b) To have approved procedures to identify, assess and establish a treatment plan for Cal MediConnect Beneficiaries with complex or serious medical conditions.

(c) To provide access to benefits in a manner described by CMS and DHCS.

(d) To protect Cal MediConnect Beneficiaries who are hospitalized from loss of benefits through the period of time CMS premiums are paid.

(e) To work with MHN/Health Net in conducting a health risk assessment of all new Cal MediConnect Beneficiaries within ninety (90) days of the effective date of enrollment.

(f) To not employ or contract with individuals excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act.

(g) To adhere to Medicare's appeals, expedited appeals and expedited review procedures for Cal MediConnect Beneficiaries, including gathering and forwarding information on appeals to Health Net, as necessary.

(h) That Cal MediConnect Beneficiaries' health services are being paid for with Federal funds, and as such, payments for such services are subject to laws applicable to individuals or entities receiving Federal funds.

(i) For purposes of Cal MediConnect Beneficiaries, retroactive eligibility changes shall be limited to thirty six (36) months or as otherwise required by CMS and DHCS.

SECTION 5
RESIGNATIONS AND NETWORK TERMINATIONS

Resignations and Network Terminations

Resignations

If a provider wishes to resign from MHN's provider network for the Cal MediConnect business, they must give one hundred eighty (180) days prior written notice to MHN. MHN will assist enrollees with transitioning to another provider if their provider resigns from the MHN network. It is the responsibility of providers to work with MHN to provide continuity of care for any Cal MediConnect enrollee they are seeing.

Termination of Network Participation

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

- Advocated on behalf of a enrollee
- Filed a complaint against MHN
- Appealed a decision of MHN
- Requested a review or challenged a termination decision

If a Cal MediConnect enrollee is receiving services on the date the provider's contract with MHN terminates upon MHN's request, the provider must continue to provide services until the later of:

a) treatment is completed;
b) such enrollee is discharged from an inpatient facility;
c) such enrollee is assigned to another provider; or
d) the anniversary date of the Cal MediConnect enrollee's benefit program.

MHN will assist enrollees with transitioning to another provider if their provider is terminated from the MHN network.

Compensation for such services will be at the rates contained in their MHN provider contract. If the provider's services are continued beyond the termination of their contract, provider will be subject to the same contractual terms and conditions that were imposed on the provider prior to the termination.

Types of Terminations

Termination with Clinical Cause

If MHN considers terminating a provider from the network for Clinical Cause, MHN will offer that provider the opportunity for a reconsideration or a hearing, as required by state regulation. MHN will notify the provider of the issues concerned and, where applicable, the reconsideration or hearing process.

Termination without Clinical Cause

MHN may terminate providers without clinical cause in accordance with the provider contract, based on the recommendation of the Credentialing Committee. Providers terminated from the network without clinical cause are offered appeal rights per MHN's Credentialing Policies and applicable state and federal regulations.

More information regarding Termination provisions is contained in the MHN Participating Provider Agreement.

SECTION 6

ENROLLEE RIGHTS & RESPONSIBILITIES

Enrollees have the right to:

• Receive information about the organization, its services, its providers and enrollee rights and responsibilities
• Be treated with respect and recognition of their dignity and right to privacy
• Participate with providers in making decisions about their health care
• A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
• Voice complaints or appeals about the organization or the care it provides
• Make recommendations regarding the organization's enrollee rights and responsibilities policies

Enrollees have the responsibility to:

• Supply information (to the extent possible) that the organization and its providers need in order to provide care
• Follow plans and instructions for care that they have agreed on with their providers
• Understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible

SECTION 7
NETWORK ADEQUACY & PROVIDER AVAILABILITY STANDARDS

7.1 Individual Providers

A. Network Adequacy

MHN complies with Medicare's network adequacy standards. CMS requires that 90% of the beneficiaries have access (maximum time/distance) to providers, and MHN's network includes the minimum number of providers and hospital beds. The requirements vary by county classification and provider type. Health Net's Provider Network Management (PNM) Department produces a *Medicare Adequacy Detail by County* report for the Cal MediConnect service areas. Behavioral Health providers are included in the analysis.

B. Provider Availability

Per contract with MHN, providers should be available and accessible to enrollees during reasonable hours of operation, with provision for after-hour services, if applicable. They must notify MHN of any changes in their hours of operation, or lapses in their availability to see MHN enrollees per Cal MediConnect program requirements, which is at least 90 days prior to any change to their availability or location of

covered services. MHN expects providers to return telephone calls from enrollees referred by MHN (for routine referrals) within 2 business days.

Provider information regarding hours of operation is collected in various ways. Providers report their operating hours when undergoing credentialing and re-credentialing. They may also report changes via MHN's Provider Portal, via MHN's Professional Relations queue at 1 (800) 541-3353 and/or via email at Professional_Relations@mhn.com.

MHN's access standards are the following:

- For *Emergent* appointments clients should be seen within 6 hours of referral.
- For *Urgent* situations, enrollees should be seen within 48 hours of referral.
- For *Routine* situations, enrollees should be seen within 10 business days (14 calendar days) of referral.

Enrollees who cannot schedule a routine appointment within 10 business days are given a re-referral to another provider.

7.2 No New Referral Periods

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

- **Vacation**
- **Personal Leave**
- **Full Practice**
- **Other Personal Reasons**

Providers can contact MHN Professional Relations department via phone or email to set up a "no referral" period. They may also make this change through MHN's Provider Portal. Providers must have a start and end date indicating when they will be available again for referrals. A "no referral" period will end automatically on the set end date.

MHN Professional Relations Department
Professional.Relations@mhn.com
(800) 541-3353
https://www.mhn.com/provider/start.do

7.3 Facility Providers

A. Network Adequacy

MHN complies with Medicare's network adequacy standards. CMS requires that 90% of the beneficiaries have access (maximum time/distance) to providers, and MHN's network includes the minimum number of providers and hospital beds. The requirements vary by county classification and provider type. Health Net's Provider Network Management (PNM) Department produces a *Medicare*

Adequacy Detail by County report for the Cal MediConnect service areas. Behavioral Health providers are included in the analysis.

B. Facility Access and Availability

Per contract with MHN, network facilities should be available and accessible to enrollees during reasonable hours of operation. Emergency care, where applicable, should also be available and accessible 24 hours a day. Facility information regarding hours of operation is collected by MHN during credentialing. Facilities must notify MHN of any changes in their hours of operation, or lapses in accessibility availability as per Cal MediConnect program requirements, which is at least 90 days prior to any change to their availability or location of covered services.

SECTION 8
ENROLLEE ACCESS TO PROVIDERS

8.1 Provider Searches

Cal MediConnect enrollees can access a listing of providers in their area by using Provider Search on www.mhn.com or calling our 24-hour access line to obtain assistance locating a provider. MHN maintains a provider database with complete demographic information, licensure, provider self-ratings on clinical - specialties, and geographical areas served, and this information is uploaded to MHN's on-line directory. This directory also lists whether provider offices have handicap accessibility.

Providers may contact the MHN Professional Relations department via phone or email to submit changes of information as needed. Providers can also update their demographics and/or profile via MHN's Provider Portal at www.mhn.com.

8.2 Re-referrals

A "re-referral" is a second referral given at the request of a Cal MediConnect enrollee who wishes to change providers. MHN can issue a re-referral will be given any time if service from the initial referral a former referral was has been made but services are not yet completed. Requests for re-referral may be administrative or clinical in nature. Re-referrals will be granted regardless of whether or not a patient has contacted or seen the formerly referred provider. MHN will provide up to two re-referrals upon request when the reason for the referral is administrative. Further requests for re-referral in addition to any request that is clinical in nature will be reviewed by a licensed clinician.

8.3 Urgent, Emergent & Routine Referrals

Life-threatening Emergent refers to those referrals for service, which require immediate evaluation.

Emergent refers to those referrals for service, which require evaluation within six hours.

Urgent refers to those referrals for service, which require evaluation by a licensed mental health professional within 48 hours.

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

SECTION 9
ENROLLEE ELIGIBILITY

Routine outpatient therapy and medication management sessions do not require pre-authorization; instead, these services are "registered" with MHN. MHN withholds authorizations for routine services requiring approval until it verifies an enrollee's eligibility status. If the eligibility status cannot be determined during the initial call, MHN personnel will not approve the service. Clinically emergent or urgent care may be arranged and delivered during the validation process; with the understanding that the enrollee is responsible for all claims should eligibility be absent. MHN will pay for one outpatient emergent or urgent session for patients if MHN arranges the session and the service is delivered within 48 hours from the time of the initial call. MHN will inform the enrollee when his or her eligibility status is determined.

Eligibility status is subject to change due to a variety of reasons possible circumstances (i.e., elective change of benefit plan). Providers should require that their patients advise them of any eligibility changes and monitor their patients' eligibility as a good business practice. Providers can call the Enrollee Service team (listed on back of patient's ID card) if they have questions about eligibility status. Providers are responsible to reimburse MHN for payments made for services rendered to ineligible enrollees.

SECTION 10
COORDINATION OF BENEFITS

Cal MediConnect enrollees are enrolled in both Medicare Advantage and Medi-Cal managed care, so determining the primary insurer is not applicable. Care is provided based on integrating the benefits, utilizing Medicare Advantage as the primary benefit and Medi-Cal managed care as the secondary benefit

- A Cal MediConnect enrollee's Medicare Advantage HMO benefits are the enrollee's primary benefit
- These benefits include medically necessary services, such as acute care services, physician services, outpatient and inpatient behavioral health services, hospital services, temporary skilled nursing facility (SNF) services, dialysis, durable medical equipment and home health care services.
- A Cal MediConnect enrollee's Medi-Cal managed care benefits provide secondary benefits and generally cover services not covered under the Medicare Advantage HMO benefits
- This may include transportation, dental, vision and some specialty mental health services. It also includes services delivered after the Medicare Advantage HMO benefit is exhausted or specific criteria has not been met, and services including long term care, custodial nursing facility care, home, community-based services and personal care services

SECTION 11
MHN LEVEL OF CARE AND TREATMENT CRITERIA –

MHN uses InterQual Criteria for reviewing cases. InterQual Criteria helps improve consistency in decision making by evaluating patient-specific behaviors and symptoms to help make clinically appropriate decisions. By using this criteria, our Care Managers are applying objective, evidence-based criteria to support their decisions regarding procedures, levels of care, and continued stay. Supporting appropriate care decisions can lead to better outcomes for our enrollees. InterQual Criteria are nationally recognized evidence-based treatment guidelines produced by the McKesson Company.

MHN reviews all authorization decisions using the InterQual Criteria; in addition, MHN also reviews the plan of treatment for appropriateness and timeliness. Details on elements used in treatment plan reviews and clinical practice are posted on www.mhn.com. It is MHN's policy to share specific level of care guidelines and utilization management review procedures in writing with providers, enrollees, customers, and enrollees of the general public who request them. Copies of criteria can be obtained by calling MHN:

For Providers:
Professional Relations
(800) 541-3353
9:00 – 1:00 PM Central
Monday - Friday

For Enrollees:
Call the specific number listed on the back of your ID card.

SECTION 12

UTILIZATION MANAGEMENT – OUTPATIENT SERVICES

12.1 General Policies for Outpatient Services

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

Authorization vs. Registration

Outpatient Authorization

MHN does not require authorization for routine outpatient services. Covered routine outpatient services include, but not limited to:

Psychiatric diagnostic interview
Individual Therapy
Family Therapy
Group Therapy
Medication Management

Prior authorization is required for psychological and neuropsychological testing. Authorization requests should be made by telephone; requests are handled by MHN Care Managers.

Registration

Enrollees and/or providers are encouraged to register outpatient treatment by calling the number on the back of the enrollee's ID card. Registration is a way to verify benefits and eligibility, however not a guarantee of payment.

12.2 Concurrent Review

MHN does concurrent review on less than 5% of outpatient cases. MHN uses an outpatient management database to identify providers who may have practice patterns that are at significant variance to MHN expected treatment norms.

A specific group of algorithms have been developed by MHN to trigger Care Management review. The goal is to identify potential outliers in practice patterns and collaboratively improve quality of care. The algorithms include the following:

- Major Depression with No Psych/Medication Evaluation after 12 visits
- Obsessive Compulsive Disorder with No Psych/Medication Evaluation after 20 visits

- Panic Disorder with No Psych/Medication Evaluation after 20 visits
- Generalized Anxiety Disorders with no Psych/Medication Evaluation after 30 visits
- Adjustment Disorders with greater than 25 sessions
- Complex service codes used as the standard session type

"Exception" reports are regularly generated for MHN Supervisor review. If the Supervisor identifies practice patterns that suggest variance from clinically accepted guidelines, these provider/enrollee combinations are assigned to a licensed Clinical Care Manager for clinical review. The Care Manager does a full review of all of any case notes and enrollee history in order to better understand the clinical situation and history of treatment. If based on the clinical aspects of the case, the Care Manager decides that no further intervention is required; they will consider the review complete. If further discussion is indicated, they will contact the provider for a discussion of the enrollee's clinical status, current signs and symptoms, the provider's goals and milestones of treatment, and how the current treatment plan is designed to meet these goals.

MHN has found that in most cases, the providers are very open to a collegial, collaborative discussion and often will accept the Care Manager's offer of assistance; for instance to arrange a for a medication evaluation, or an adjustment in the treatment plan with an agreement to review again at a later, mutually established time. In those infrequent cases, where the Care Manager feels that a denial of care may be warranted or the case is of an unusual nature, the Care Manager will consult with a MHN Medical Director to determine the next steps. MHN has found that due to this collaborative process with providers, very few of these result in denials. Overall, this process has been very well received by the provider community.

Minors and/or Adults Unable To Give Consent and Consent for Treatment; Consent for Release of Information

MHN and its contracted providers have a responsibility to recognize and help protect the rights of minors and adults unable to give consent. When consent for "Release of Information" or treatment are necessary for enrollees who are minors or adults unable to give consent, the provider should obtain written consent from a parent, legal guardian, or other appropriate individual or agency.

The completed consent for treatment or "Release of Information" form should be in the provider's treatment record. When provider treatment records are audited against treatment record standards, consents should be present when records pertain to enrollees who are minors or adults unable to give consent.

SECTION 13

UTILIZATION MANAGEMENT - HIGHER LEVELS OF CARE

13.1 General Policies

This section describes authorization for higher levels of care (inpatient psychiatric, residential treatment, partial hospitalization, structured outpatient, inpatient detoxification, substance abuse rehabilitation) using

the MHN Level of Care Criteria and Medical Necessity Guidelines for admissions outlined in this manual.

A. Pre-certification

MHN has licensed clinical staff available 24 hours a day, seven days a week for precertification of patient care. Patient care is pre-certified when a treating provider or facility provides initial clinical information and requests authorization PRIOR to admission.

B. Initial Authorization

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

C. Concurrent Review

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

D. Non-certification

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

13.2 Procedures

A. Pre-certification

1. Facility provider must call MHN 24-hour group access numbers and request precertification.
2. MHN Care Managers conduct precertification reviews according to the following guidelines:

    1. The Care Managers assess the patient's clinical presentation according to the *MHN Level of Care Criteria and Medical Necessity Guidelines* for the specific care setting and intensity of service that is being proposed. This assessment includes the patient's presenting problem, mental status, current diagnosis, previous psychiatric/substance abuse treatment and relevant psychosocial factors.
    2. If the *MHN Level of Care Criteria and Medical Necessity Guidelines* are met, then the facility provider of care is given the appropriate verbal authorization. If the precertification occurs during non-regular business hours, the authorization is given "pending eligibility verification" and the facility provider is instructed to admit the patient to the proposed care setting, but to then contact MHN during regular business hours for eligibility verification.
    3. If the *MHN Level of Care Criteria and Medical Necessity Guidelines* are not met, then the facility provider is notified verbally and an alternative care plan or setting is discussed. If agreement is reached on an alternative care plan or setting, written confirmation of this

agreement is provided. If the plan or setting cannot be agreed upon, the Care Manager explains the denial process to the provider and refers the case to an MHN Medical Director for review.

B. Initial Authorization

1. Facility providers initiate request for authorization for all higher levels of care by telephone.
2. MHN Care Managers review requests for medical necessity, and decide upon the most appropriate level of care based on *MHN Level of Care Criteria and Medical Necessity Guidelines* for admissions.
3. If the *MHN Level of Care Criteria and Medical Necessity Guidelines* are not met for the level of care requested, the Care Manager will refer the case for MHN Medical Director review.
4. If the MHN Medical Director denies authorization, refer to the non-certification procedure.
5. Once authorization is established, the Care Manager notifies the requesting facility of the decision and sets a date for the concurrent review.
6. The Care Manager generates an authorization verification letter to be mailed to provider and patient.

C. Concurrent Review

1. The attending physician or facility utilization review staff calls the MHN Care Manager on the agreed upon review date and provides and verifies the concurrent review information.
2. The Care Manager obtains all the following information required for concurrent review via telephone with the utilization review staff or attending psychiatrist at the facility:
    - Diagnosis
    - Symptom progress/change in severity
    - Risk areas
    - Treatment goals/interventions
    - Medications
    - Indicators for continued treatment
    - Discharge planning (to begin within twenty-four hours of admission)
    - Target discharge date
3. The Care Manager reviews clinical data and authorizes additional days if the *MHN Level of Care Criteria and Medical Necessity Guidelines* for continued stay are met.
    - If the MHN Level of Care Criteria and Medical Necessity Guidelines for continuing stay are not met for the level of care requested, the Care Manager will review the request with a MHN Medical Director.
    - If the MHN Medical Director denies authorization, refer to the noncertification procedure.
    - The Care Manager documents clinical appropriateness.
    - The Care Manager reviews with a clinical manager and/or MHN Medical Director when any aspect of the treatment plan is unclear and/or is in question.

D. Non-certification

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

1. The MHN Care Manager receives requests for authorization by telephone from the clinical contact at the facility or program.

2. Administrative denials (based on exhaustion of benefits, lack of pre-authorization, etc.) do not require MHN Medical Director review.
3. When *MHN Level of Care Criteria and Medical Necessity Guidelines* are not met, the Care Manager presents the case to the MHN Medical Director for review. In the case of clinical denials, the facility is notified by the Care Manager that they can request a peer to peer discussion with the Peer Reviewer who originally denied the authorization. If the decision then remains unacceptable, the patient or patient's representative (often the facility) can request an expedited telephonic appeal by a different Peer Reviewer if the patient is still in treatment.
4. Notification of denial of authorization is made by telephone immediately. Written confirmation is then sent within one business day to the facility, attending physician and patient.
5. The original denial letter is sent to the patient and copies are sent to the facility, parent and/or guardian (if applicable) and attending physician. The denial letter will always include the rationale for the denial decision and a full description of the appeals procedure.

In the case of inpatient treatment services where the enrollee is still hospitalized, a provider who would like to appeal a denial immediately on behalf of the enrollee is verbally notified of the urgent appeals process in which the facility representative (e.g., attending physician) can speak with another Peer Reviewer to present the case.

BEHAVIORAL HEALTH COORDINATION AND CONTINUITY OF CARE

MHN offers continuity of care assistance for new Cal MediConnect enrollees who are receiving care from a non-MHN network practitioner or provider for a current episode involving an acute, serious, or chronic mental health condition. This determination takes into consideration the potential clinical effect of a change of provider on the enrollee's treatment for the condition. If authorized, MHN allows the enrollee a reasonable transition period (subject to the benefit limit) to continue his or her course of treatment with the non-participating practitioner prior to transferring to a participating practitioner. MHN authorizes services according to state and federal regulation and the parameters of the specific transition benefit the enrollee's employer group has purchased.

Practitioners, providers, or Cal MediConnect enrollees may request continuity of care assistance by contacting MHN directly. MHN intake representatives obtain the information necessary to authorize care. If additional clinical information is needed, the intake representative refers the call to an MHN care manager. MHN care managers are licensed behavioral health professionals, and authorize services and consult as needed with an MHN physician advisor. MHN notifies the requesting practitioner, provider, or Cal MediConnect enrollee by telephone of the continuity of care decision.

Except for behavioral health and substance abuse services, all other Medicare covered services, including prescription medications, continue to be coordinated by the enrollee's primary care physician (PCP). Providers treating enrollees without MHN benefits should assess for behavioral health needs and refer as appropriate.

SECTION 14
QUALITY IMPROVEMENT

14.1 Enrollee Surveys

To ensure understanding of enrollees' ability to access services, efficiently navigate MHN processes, and receive effective behavioral health service, MHN administers an enrollee survey instrument. This instrument also assesses enrollees' level of satisfaction with MHN, as well as identifying their perceived value of services and any improvements they identify from services they have obtained. The results from these survey are is used to both inform interventions to improve MHN's processes and systems , as well as assess the MHN network of providers to ensure optimal provider performance

14.2 Potential Quality Issues

Potential quality issues (PQIs) are quality concerns identified by MHN enrollees, staff, or accounts. When any staff enrollee identifies a PQI, a QM clinical staff enrollee conducts a review of the case. This review may include contacting the enrollee or provider, or reviewing treatment records. Outcomes of PQI reviews are forwarded to the Credentialing Committee and/or Quality Improvement Committee.

14.3 Quality Review

MHN conducts peer review of cases where there has been a complaint or potential quality issue. In addition, we review providers whose profiles indicate potential problems. MHN's QI Department and MHN Professional Relations work collaboratively to make decisions on any corrective action to be taken regarding a provider.

14.4 Provider Satisfaction

MHN seeks out information on provider satisfaction with our system. On an annual basis, we send out a Provider Satisfaction Survey to a sample of providers. The survey asks about satisfaction with specific types of staff and with processes. When the average rating on any question falls below "good", we implement a corrective action plan.

14.5 Data Collection and Shared Metrics for Cal MediConnect

MHN and Health Net evaluate the effectiveness of the Model of Care for Cal Medi Connect beneficiaries through the use of regular data collection, analysis and reporting. Participating providers must cooperate with Health Net/MHN's collection of data to meet the shared QI metrics requirements of the Cal MediConnect Program.

SECTION 15

ENROLLEE PROBLEM RESOLUTION, COMPLAINTS, APPEALS & GRIEVANCES, AND PROVIDER DISPUTES

15.1 Enrollee Problem Resolution and Complaints

A. General Enrollee Inquiries

MHN’s Cal MediConnect Project Customer Service Representatives (CSRs) are trained to answer enrollee inquiries and concerns from enrollees and prospective enrollees.

CSRs are trained to perform the following functions within the scope of their responsibilities, but not limited to:

- Explain the steps a prospective enrollee must take to enroll with the plan.
- Answer questions about Benefits, Plan Design and Eligibility.
- Explain the process for accessing covered services.
- Assisting the enrollee with locating a physician/facility/pharmacy.
- Warm-transfer an enrollee to the Public Program Coordinators (PPC) department if they have questions about state-covered services or resources.
- Provide enrollees with the identity, locations and availability of providers
- Explain the Prior Authorization process.
- Explain the status of an enrollee’s Claims that have been received by MHN.
- Explain the steps an enrollee must take to file an Appeal or Grievance.
- Assist an enrollee with filing an Appeal or Grievance.
- Explain the steps an enrollee must take to disenroll with the plan.

B. Enrollee Complaints

Any enrollee can express dissatisfaction with any aspect of treatment, care or service by calling the number for MHN provided to them on their benefit card or in their benefit materials. Enrollees may also choose to fax or mail a written complaint to an MHN Service Center or directly to the Appeals & Grievances Unit. Contact numbers are located at the beginning of this Manual. Enrollees may also file a formal complaint on-line with the specific form available for that purpose at MHN.com. All complaints will be handled quickly and respectfully. Exempt Complaints will be resolved within 1 business day. Formal complaints will be resolved within 30 calendar days of receipt by MHN, including notification to the enrollee of the resolution (or within more stringent state or account standards). If the issue is urgent, the safety issues will be addressed within 24 hours. MHN does not delegate complaints. There is no time limitation on an enrollee's right to file a complaint. No special identification will be made or action taken against any enrollee as a result of having expressed dissatisfaction with MHN or any of its network providers.

The fact that an enrollee submits a grievance or complaint to MHN must not affect in any way the manner in which the enrollee is treated by the participating provider. Enrollees have the right to express dissatisfaction or concern and to expect prompt resolution without fear of retaliation or adverse effect on the care they receive.

CMS Assistance

Enrollees are expected to use MHN's grievance procedures first to attempt to resolve any dissatisfaction. If the grievance has been pending for at least 30 days with no response from MHN or Health Net, or the grievance was not satisfactorily resolved by MHN or Health Net, the enrollee may seek assistance from the Centers for Medicare and Medicaid Services (CMS). Participating providers may assist the enrollee in submitting a complaint to CMS for resolution and may advocate the enrollee's position to CMS. No participating provider can be sanctioned in any way by MHN or Health Net for providing such assistance or advocacy.

CMS requires that the following note be placed in all correspondence pertaining to quality of care grievance cases:

> Please note that you may also file a written grievance with the Health Services Advisory Group (HSAG), the Quality Improvement Organization (QIO) designated for the State of California. Providers and health care experts at HSAG review quality of care complaints made by Medicare enrollees regarding coverage. Contact HSAG for additional information on quality of care grievances.

15.2 Enrollee Appeals and Provider Disputes

MHN's appeals process has been established to offer enrollees the opportunity to appeal decisions to deny coverage or payment. MHN's Provider Dispute Resolution process has been established to also give providers and facility providers rights to appeal (aka dispute) utilization management decisions for both medical necessity or benefit coverage reasons. Medical necessity provider disputes are reviewed by a Peer Reviewer other than the MHN reviewer who made the initial determination not to authorize the services.

MHN has not been delegated for any level of Medicare enrollee appeals. These are handled by Health Net. MHN has been delegated to handle non-contracted provider appeals regarding services with Medicare Advantage enrollees and handles all types of Provider Disputes and provider appeals.

Enrollee Appeal Categories:

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

Pre Service Appeal: The enrollee has a right to a pre-service appeal whenever they are awaiting treatment or are in treatment and wish to continue. Providers/facility providers can, with the enrollee's

permission, appeal on their behalf. Pre-service appeals are resolved as expeditiously as the clinical circumstances warrant, (generally within 1-3 calendar days), but in no event more than 30 calendar days from the date of the appeal request. Enrollees are sent an acknowledgement in writing within 5 calendar days of receipt. Enrollees or providers have the right to submit, if they wish, any information or collateral material relevant to the appeal either telephonically, by fax, or in writing. This enrollee appeal is completed by a Peer Reviewer other than the one who made the initial decision not to authorize services.

Post Service Enrollee Appeal: Enrollee appeals that are received, either verbally or in writing, after services have been rendered are acknowledged in writing within 5 calendar days of receipt and are resolved within 30 calendar days. Enrollees or providers have the right to submit, if they wish, any information or collateral material relevant to the appeal either telephonically, by fax, or in writing. This enrollee appeal is completed by a Peer Reviewer other than the one who made the initial decision not to authorize services. With regard to Post Service Clinical Provider Appeals, MHN will acknowledge such appeals within 5 calendar days and MHN will complete the review and provide a determination within 30 calendar days. There are no extensions of the time-frame or stopping of the clock while waiting for additional information to be submitted.

Under the Affordable Care Act, enrollees are also entitled to an external review process. This regulation applies to most MHN plans. Details about the availability of external review as well as submission directions are provided with all applicable resolution letters.

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

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

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

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

Who decides if the situation is urgent?

- A medical provider with knowledge of the patient’s medical condition or MHN’s Medical Director will decide if the situation is urgent or not.

How do you file an expedited or urgent appeal?

- You or your patient may file an expedited or urgent appeal verbally by calling the HN Medicare/Medi-Cal CCC line at (800) 275-4737.

Health Net/MHN will respond as soon as possible, but no longer than 72 hours. Health Net/MHN will deliver our response verbally, and will issue it in writing no later than 72 hours after the request. The patient may even have the option to request a review from a certified independent review organization before Health Net/MHN's internal review is complete.

- If you need to file an urgent appeal, we suggest the patient, the patient's authorized representative, or the provider call the HN Medicare/Medi-Cal CCC line at (800) 275-4737 immediately.

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

You may file a non-expedited or non urgent appeal in writing to:

Health Net, Grievances and Appeals,
P.O. Box 10350,
Van Nuys, CA 91410-0350.

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

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

15.3 Provider Dispute Resolution

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

The first steps towards resolving a dispute are outlined below.

NOTE: The majority of issues with authorizations, claims can be resolved through Customer Service or the Service Team.

1. If you have a concern involving a claims payment issue, please call our Claims Customer Service Department at (800) 444-4281.

2. If you have a concern regarding authorizations and/or wish to access care for an enrollee, please call the MHN Service Team. This number is referenced in your authorization letter and/or should be listed on the back of the enrollee's medical insurance ID card.

3. If you have a concern that involves a contracting status, please call our Professional Relations representatives at (800) 541-3353.

4. For cases where authorization has been denied because the case does not meet medical necessity criteria, please follow the dispute resolution process below.

5. If you suspect fraud or abuse in the provision of services or submission of claims, please contact our Fraud & Abuse Hotline at (800) 327-0566.

Dispute Resolution Process

If the steps outlined above do not fully resolve your concern, please use the Provider Dispute Resolution Request Form. If you need to submit a group of multiple claims that are similar in nature (i.e., "like" claims), please complete the Multiple Claim Submission Form.

Definition of Contracted Provider Dispute

A contracted provider dispute is a provider's written notice to MHN challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim.

Each contracted provider dispute must contain, at a minimum, the following information: provider's name, billing provider's tax ID number or MHN's provider ID number, provider's contact information, and:

- If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from MHN to a contracted provider the following must be provided: original claim form number (located on the RA), a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;
- If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue; and
- If the contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service and provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

Sending a Contracted Provider Dispute to MHN

Contracted provider disputes submitted to MHN must include the information listed in Section III.A., above, for each contracted provider dispute. To facilitate resolution, providers should use the Provider

Dispute Resolution Request form to submit the required information. All contracted provider disputes must be sent to the attention of Provider Disputes at the following:

MHN
Provider Disputes
P.O. Box 10697
San Rafael, CA 94912

Time Period for Submission of Provider Disputes

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

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

Acknowledgment of Contracted Provider Disputes

MHN will acknowledge receipt of all contracted provider disputes within fifteen (15) business days of the Date of Receipt by MHN.

Contact MHN Regarding Contracted Provider Disputes

All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute or other inquiries must be directed to the Provider Dispute Department at MHN at (888)-444-4281.

Instructions for Filing Substantially Similar Contracted Provider Disputes

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

Time Period for Resolution and Written Determination of Contracted Provider Dispute

MHN will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) business days after the Date of Receipt of the contracted provider dispute or the amended contracted provider dispute.

Past Due Payments

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

Billing

Do not bill enrollees for days denied by MHN. Your contract does not permit it. Instead, please submit the Provider Dispute Resolution Request form with the required information to the address listed above. Dispute Resolution Process for Non-Contracted Providers.

Claim Overpayments

Notice of Overpayment of a Claim

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

Contested Notice

If the provider contests MHN's notice of overpayment of a claim, the provider, within 30 business days of the receipt of the notice of overpayment of a claim, must send written notice to MHN stating the basis upon which the provider believes that the claim was not overpaid. MHN will process the contested notice in accordance with MHN's contracted provider dispute resolution process described in Section III above.

No Contest

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

SECTION 16
BILLING & REIMBURSEMENT

16.1 General Policies

- As a condition of payment, providers must bill for services within 180 days after the month in which the service is rendered, unless provider demonstrates good cause for failure to timely submit claim.
- **Health Net Cal MediConnect enrollees do not have copayments and participating providers must not collect copayments for services.**

- Providers should submit claims with their charges however, in no event shall the rates payable under the Provider's Participating Provider Agreement (MHN contract) exceed the amounts billed by the provider.
- **Providers may not balance bill enrollees.**
- Providers must advise enrollees in writing prior to providing excluded services that services will not be covered by MHN and enrollee will be responsible for paying the provider directly for these services.

The following time requirements for payment by MHN are included in the MHN Provider Agreement:

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

16.2 Outpatient Billing Procedures

For outpatient treatment you may submit claims electronically or bill MHN using the CMS (HCFA)-1500.

MHN's contract indicates that claims shall be paid only if they meet the requirements for claims submission, including timely submission. All dates of service submitted greater than 180 days after the month services were rendered will be reviewed for "timely filing" and potentially denied.

To help you submit complete and correct information, you may log in to our Provider Portal at www.mhn.com to verify subscriber information and enrollee eligibility before submitting claims. This will enable you to confirm that the correct information is being submitted and will help eliminate delays in processing your claim.

All claim information must be submitted via electronic claims submission or on a standard CMS (HCFA) 1500 or UB 04 form in order for the claim to be accepted into MHN's claim system. This includes requests for missing information, which must be resubmitted on a corrected claim form to:

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

If you have a concern involving a claims payment issue, please call our Customer Service team at (800) 444-4281.

A. Electronic Claims Submission

Using MD On-Line

You can submit electronic claims directly to MHN for free via MD On-Line. To set up an account, visit the MD On-Line website. If you need help regarding the MD On-Line website, please call their Help Desk at (888) 397-3434.

Using Emdeon (formerly WebMD)
MHN also accepts electronic submission of both Professional and Institutional claims through Emdeon. If your practice management system uses Emdeon as its clearinghouse, you can submit claims using MHN's payer ID: 22771. To find out if your practice management software uses Emdeon's clearinghouse, check with your vendor. For more information about Emdeon services, call (877) GO-WebMD (469-3263) or visit: www.emdeon.com.

B. Paper Claims Submissions

Paper claims must be submitted using a CMS (HCFA)-1500. Claims which do not include all of the required information will be returned to the provider for completion and resubmission. Your claim MUST include:

- Correct Subscriber/Insured ID number
- Subscriber/Insured name
- Subscriber/Insured address
- Patient Name
- Patient address
- Patient Date of Birth
- Provider Name
- Provider Tax Identification Number
- Provider's servicing address, zip code and phone number
- Billing Provider address, zip code and phone number
- Date(s) of Service
- Diagnoses Codes
- Current year CPT Procedure Code(s)
- CMS Place of Service Code
- Number of days or units
- Billed Charges

C. MHN Billing Instructions for CMS (HCFA) – 1500 Billing Form
Please type or print clearly; the form will be scanned.

Definitions

- Insured: The primary holder of the insurance (typically the employee).
- Patient: The person accessing the service (may be the subscriber or a dependent of the subscriber).
- Insured ID Number: The number used by the insurance company to identify the insured person. It is printed on their insurance card.
- Place/Type of Service: A 2-digit code that designates where services were performed (e.g., home, hospital, office, clinic, etc.). For example, an office visit with a provider is code "11."
- Diagnosis Code: Represents why service is being sought. Enrollees may obtain this code from their provider. It is also typically on the receipt for service if you are an enrollee filing a claim.

CPT Procedure Code: A code designating the type of service received. Enrollees may obtain this code from their provider. It is also typically on the receipt for service if you are an enrollee filing a claim.

The following are required fields:

- Box 1 – Indicate the type of insurance coverage applicable to this claim by checking the appropriate box.
    - Box 1a – Insert correct insured/ID number.
- Box 2 – Enter the patient's name as it appears on the insurance card or benefit enrollment forms (i.e., last name, first name).
- Box 3 – Enter the patient's date of birth in MM/DD/YYYY format. Check appropriate gender box.
- Box 4 – Enter /insured name in last name, first name format (e.g., Doe, John).
- Box 5 – Enter the patient's mailing address and telephone number.
- Box 6 – Check the appropriate box for the patient's relationship to the insured.
- Box 7 – Enter the insured's mailing address and telephone number.
- Boxes 9 through 9d –These are required if the patient is covered by more than one health plan/insurance policy.
  Box 9 – Enter the full name of the other person under whose insurance the patient is also covered.
  Box 9a – Enter the insured's policy or group number.
  Box 9b – Enter the insured's date of birth and gender.
  Box 9c – Enter the employer or school information for the subscriber.
  Box 9d – Enter the plan or program name for the insured's health plan.
- Boxes 10a through 10c – Check "yes" or "no" to indicate whether employment, auto accident or other accident involvement applies to one or more of the services being billed.
- Box 12 – Enter the patient's signature to authorize release of medical information necessary to process the claim. If the patient is a minor child, a parent or legal guardian should sign. Signatures can be "signature on file" and/or computer-generated signature.
- Box 13 – The patient's signature in this box indicates that reimbursement is to be sent to the provider of service at the address indicated in Box 33. This can be" signature on file" and/or computer-generated signature. If the insured is to be reimbursed, this box should be left BLANK. (Note: if Box 13 is left blank reimbursement will be sent to the insured, whether or not the insured is also the patient.) Do not put any text in this box other than the signature or "signature on file". Any text in this box may be interpreted as authorization of payment of benefits to the provider of service. If Box 29 indicates that the claim has been paid in full, the claim will be assigned to the enrollee regardless if there is a signature in Box 13.
- Box 17 – If Box 17 is completed, the corresponding NPI # must be included in Box 17b.
- Box 21 – Enter the patient's diagnosis/condition code(s). Use the highest level of specificity of DSM-IV or ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
- Box 24
    - Column A – Date(s) of service in MM DD YY format. One date of service per line. Maximum of six dates of service per claim form.
    - Column B – Enter the appropriate place of service code for each service performed (e.g., 11 = office visit)
    - Column D – Enter the procedure or services using the current CPT-4 procedure codes.

- Column E – Enter the diagnosis code reference number (as shown in Box 21) to indicate the date of service and the procedures performed.
  - Column F – Enter the charge for each of the listed services.
  - Column G – Enter the number of units.
  - Column I – The shaded field is used to identify what type of number is placed in 24J.
  - Column J – The rendering provider's NPI # belongs in the white box of 24J. The shaded box is for other identifying number the provider is allowed to submit.
- Box 25 – Enter the federal tax identification number for the treating provider or group. The claim will be returned if the Tax ID Number is not provided.
- Box 27 – Check appropriate box to indicate if the provider of service accepts Medicare assignment.
- Box 31 – Enter the printed/typed name and signature of provider of service, including degree/credentials.
- Box 32 – If Box 32 is completed, the corresponding NPI # must be included in Box 32b.
- Box 33 – Enter the name, group name (if applicable), licensure, address and phone number for the pay-to (billing) information. If Box 33 is completed, the corresponding NPI # must be included in Box 33b.

For enrollee submitted claims, please attach receipt of services from the provider.

Claims that do not include the above information will be contested by MHN. A remittance advice will be sent to the individual who submitted the claim requesting completion and re-submission.

To submit paper claims, please mail your form to:

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