	Canopy Health Provider Manual 2026	
Effective Date: 1/1/2026		
Previous Versions: see revision history on last page		

Thank you for participating in the Canopy Health network. Canopy Health is an integrated Bay Area healthcare alliance, owned by UCSF Health and Hill Physicians Medical Group. Our goal is to provide value to employers and plan members, your patients, through better access to high quality, affordable care, with an improved member experience. You are part of a network of 30 hospitals and approximately 6,500 physicians covering ten counties: Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Sonoma, and parts of Solano. Canopy Health is different in that we work with you and two select health plans (Health Net and United Healthcare) in a more collaborative way. At Canopy Health we recognize the key to our success is having exceptional providers as part of our alliance-like you! Canopy Health is a community of caregivers championing health. We believe you share this vision.

We hope you will use this provider manual as a resource to help us work together to serve our members.

Again, welcome to Canopy Health. We are glad to have you on our team.

Ken Wood

Ken Wood

Chief Executive Officer

Canopy Health

Canopy Health Provider Manual – January 2026

For:

Physicians
Other Health Care Professionals
Ancillary Providers

canopy HEALTH

Table of Contents

Introduction

Using this Guide

The Canopy Health Provider Manual contains essential information on the administrative components of Canopy Health's operations including:

- claims billing and submission, provider disputes, coordination of benefits
- prior authorization and referral information
- health care access and coordination

Definitions

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Placing the patient's health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(4) "Active labor" means a labor at a time at which either of the following would occur: (a) There is inadequate time to effect safe transfer to another hospital prior to delivery; or (b) A transfer may pose a threat to the health and safety of the patient or the unborn child.

"Health Plan" means any full-service health care service plan licensed under the Knox-Keene Act that has entered into a plan-to-plan agreement with Canopy Health for the provision and/or arrangement of covered services to members of the health plan.

"In Network" refers to Canopy Health's entire network of providers (including Medical Groups/IPAs, hospitals and ancillary providers) that have entered into an agreement with Canopy Health to provide covered services to members enrolled in specific health plan products.

"In Service Area" refers to the total geographical area designated by Canopy Health within which Canopy Health shall provide health care services. This geographical area may be a broader area than that serviced by any individual Canopy Health contracted medical group/IPA and may vary by product.

"Out of Area" refers to the geography outside Canopy Health's service area of any specific health plan product.

"Out-of-area coverage" means coverage while an enrollee is anywhere outside the service area of Canopy Health and includes coverage for urgently needed services to prevent serious deterioration of an enrollee's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee returns to Canopy Health's service area.

"State" refers to the state of California.

About Canopy Health

Canopy Health is an integrated healthcare alliance of physicians and hospitals owned by UCSF Health and Hill Physicians Medical Group. Canopy Health strives to optimize access and service in every interaction with members and providers in order to provide the highest quality care in the Bay Area. Canopy Health is licensed by the Department of Managed Health Care ("DMHC") as a Restricted Knox-Keene entity allowing Canopy Health to accept responsibility for medical costs and management of health plan enrollees. Canopy Health contracts with health plans to create unique insurance products that are high-quality, consumer focused and price competitive, offered to employers and individuals.

Canopy Health Mission

We are creating an integrated healthcare experience where quality care and coverage are provided by an alliance of top caregivers across the Bay Area, allowing people to access the best options for their personal needs. We do this in a way that is refreshingly clear, by making each unique customer's journey predictable and transparent. We believe that the best healthcare doesn't have to be unpredictable, confusing, or a financial burden.

Canopy Health Online

Canopy Health, on its website, www.canopyhealth.com, provides a directory of its complete provider network. Users can search for physicians, hospitals, and ancillary providers by specialty name, language(s) spoken, zip code, city and distance. For a printed copy of our provider directory please send request via email to chcompliance@canopyhealth.com. CALL TDD/TTY for the hearing-impaired California Relay Service (CRS) 711 or (800) 855-7100 or visit the website, where a link is provided to have a printed directory sent via USPS. Canopy Health complies with the requirements of California Health and Safety Code Section 1367.27(c)(2). To report directory errors please call 888-822-6679 and leave a detailed message.

Participating Health Plans

Role of the Health Plan with a Knox-Keene License

Under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), the California Department of Managed Health Care ("DMHC") requires licensure for any entity that assumes global financial risk for professional health services and/or hospital and other institutional health care services. Canopy Health operates under a Restricted Knox-Keene license. This type of license allows Canopy Health to assume global risk by accepting both institutional and professional risk-based capitation payments as subcontractors to unrestricted, full-service plans.

Checking Member Eligibility

Providers are responsible for verifying members' eligibility for all medical services they provide. Please check the Customer's health plan ID card at each visit and keep a copy of both sides of the health plan ID card for your records. Additionally, it is important that you verify eligibility and benefits before or at the point of service for each office visit.

Providers may verify member eligibility by contacting the Health Plan directly by calling the number located on the back of the member's ID card or utilizing the Health Plan's portal.

Health Plan Identification (ID) Cards

Canopy Health members receive health plan ID cards containing information needed for providers to submit claims. Information may vary in appearance or location on the card for different payers or other unique requirements. However, all cards display the following information:

- Identification of Canopy Health IPA/Medical Group
- Member name and ID number; group number
- Health Plan
- Copayment information
- Eligibility information

Health Plan Partners

Health Plan partners with Canopy Health for 2026 include (see below for specific geographies for each plan):

- Health Net Blue and Gold
- Health Net CanopyCare

- UnitedHealthcare Signature Value Advantage (SVA) For County of Alameda Employees only through January 31, 2026.

Canopy Health	As of January 1, 2026		
County	Health Net Blue and Gold	Health Net CanopyCare – SFHSS	UHC SVA – County of Alameda Employees through 1/31/2026
Alameda	Yes Only JMPN	Yes	Yes
Contra Costa	Yes Only JMPN	Yes	Yes
Marin	Yes	Yes	Yes
Napa	No	Yes	Yes
San Francisco	Yes	Yes	Yes
Santa Clara	No	Yes	Yes
San Mateo	Yes	Yes	Yes
Santa Cruz	Yes	Yes	Yes
Solano	Only if member lives or works in the following zip codes 94510 94591	Only if member lives or works in the following zip codes 94510 94591	Only if member lives or works in the following zip codes 94510 94591
Sonoma	Only if the member lives or works in the following zip codes 94928 94931 94951 94952 94954 95442 95452 95476	Yes	Yes

UnitedHealthcare (UHC)

UnitedHealthcare is a for-profit national managed health care company owned by UnitedHealth Group, Inc. based in Minnesota. UHC offers an HMO product called UnitedHealthcare Signature Value Advantage HMO and UnitedHealthcare Signature Value Harmony.

Providers may obtain the following information from UnitedHealthcare interactive voice response (IVR) system at **1-877-842-3210** or the UnitedHealthcare provider website at http://www.uhcprovider.com:

- Member's eligibility or benefits (including copayments, deductibles, past/current coverage, coinsurance, and out-of-pocket information) and obtain a faxed confirmation,
- Status of claims for which UHC is financially responsible,
- Update facility/practice demographic data (except TIN),
- Check credentialing status or request for participation inquiries,
- Check appeal or claim project submission process information,
- Check care notification process information,
- Check privacy practice information.

Additional information can be obtained by calling the UnitedHealthcare Health Plans Provider Call Center at 1-800-542-8789.

For member language assistance visit UHC's language assistance web page:

https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices

UHC 24/7 Nurse Advice

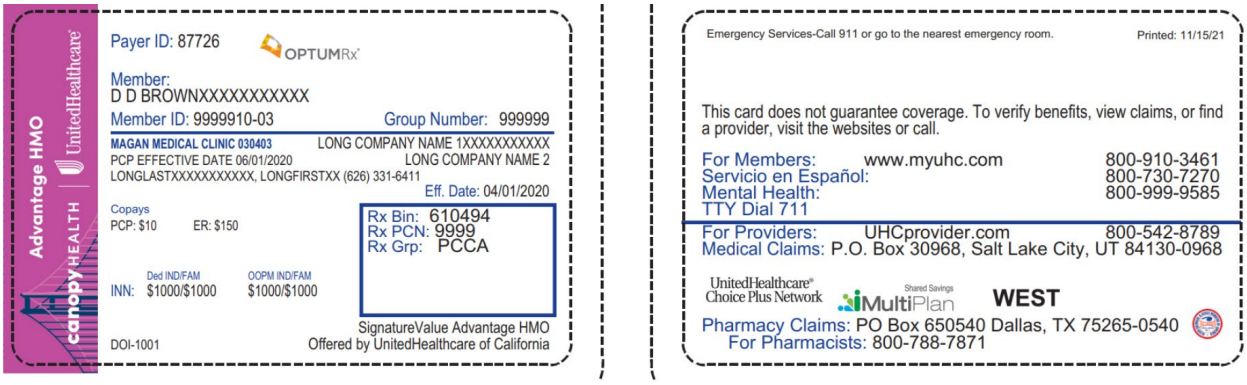
UHC provides access to an advice nurse line, accessible 24 hours a day, 365 days a year via the telephone number on members' health plan identification cards.

UHC Disease Management Programs

Disease management is currently offered by Optum telephonically for the following conditions: chronic kidney disease stage 4-5, diabetes mellitus, ESRD (only for members who are on dialysis) and heart failure.

UnitedHealthcare (UHC) Sample Health Plan Identification (ID) Card

Signature Value Advantage For County of Alameda Employees only through January 31, 2026.



Health Net

Health Net is a for-profit health care insurance company owned by Centene. Health Net Blue and Gold, Health Net SmartCare HMO, and Health Net CanopyCare members in the San Francisco Bay Area are part of the Canopy Health alliance. See grid on page 10 for participation specific to each county. Providers can obtain real-time eligibility from Health Net via the Health Net interactive voice response (IVR) system at **1-800-641-7761** or the Health Net website at http://www.healthnet.com/portal/provider/home.ndo (or go to www.healthnet.com and select "Providers").

For member language assistance visit Health Net's website:

https://www.healthnet.com/content/healthnet/en_us/members/support/language-assistance.html

Health Net 24/7 Advice Line

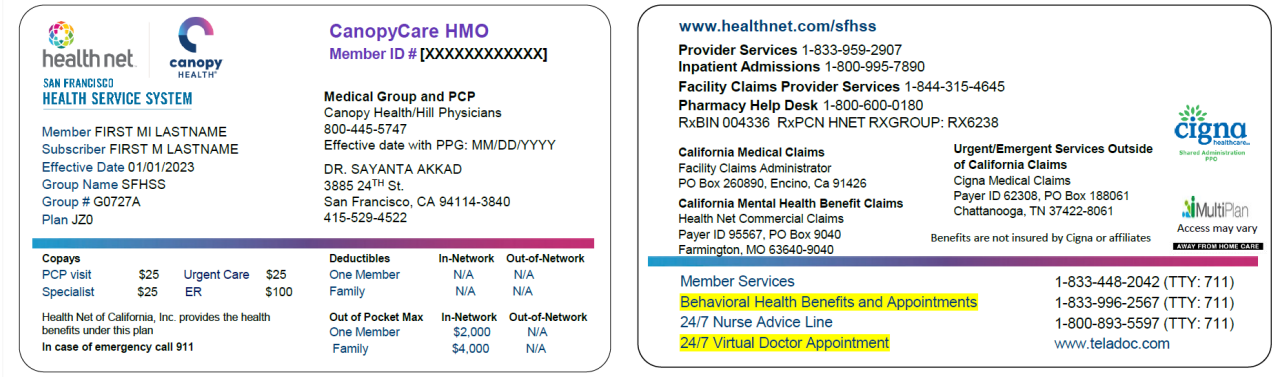
Health Net provides access to an advice line, accessible 24 hours a day, 365 days a year through Health Net's Customer Contact Center at the number on members' ID cards. California licensed registered nurses skilled in screening and triage services guide members to the most appropriate level of care along with health education services. Members can call **1-800-893-5597 (TTY 711)** to speak with a nurse.

Health Net Disease Management Programs

Health Net members are offered disease management programs for conditions such as asthma, coronary artery disease and diabetes. The programs are voluntary, and members can opt-out at any time. Providers can contact Health Net directly for detailed information or go to the Health Net website at www.healthnet.com.

Health Net Sample Health Plan Identification (ID) Card

CanopyCare (SFHSS):



health net
SAN FRANCISCO
HEALTH SERVICE SYSTEM
canopy HEALTH

Member FIRST MI LASTNAME
Subscriber FIRST M LASTNAME
Effective Date 01/01/2023
Group Name SFHSS
Group # G0727A
Plan JZ0

CanopyCare HMO
Member ID # [XXXXXXXXXXX]

Medical Group and PCP
Canopy Health/Hill Physicians
800-445-5747
Effective date with PPG: MM/DD/YYYY

DR. SAYANTA AKKAD
3885 24TH St.
San Francisco, CA 94114-3840
415-529-4522

Copays				Deductibles	In-Network	Out-of-Network
PCP visit	$25	Urgent Care	$25	One Member	N/A	N/A
Specialist	$25	ER	$100	Family	N/A	N/A

Health Net of California, Inc. provides the health benefits under this plan
In case of emergency call 911

Out of Pocket Max	In-Network	Out-of-Network
One Member	$2,000	N/A
Family	$4,000	N/A

www.healthnet.com/sfhss

Provider Services 1-833-959-2907
Inpatient Admissions 1-800-995-7890
Facility Claims Provider Services 1-844-315-4645
Pharmacy Help Desk 1-800-600-0180
RxBIN 004336 RxPCN HNET RXGROUP: RX6238

California Medical Claims
Facility Claims Administrator
PO Box 260890, Encino, Ca 91426

California Mental Health Benefit Claims
Health Net Commercial Claims
Payer ID 95567, PO Box 9040
Farmington, MO 63640-9040

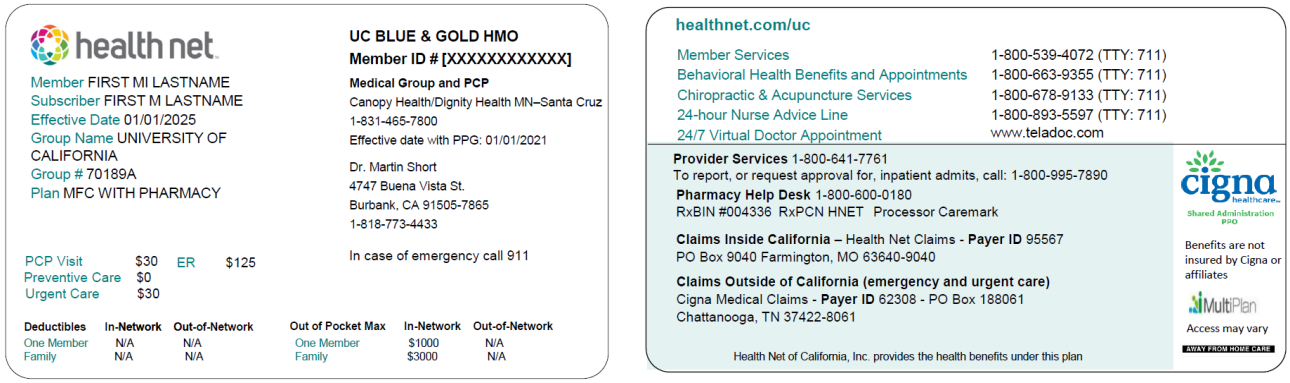
Urgent/Emergent Services Outside of California Claims
Cigna Medical Claims
Payer ID 62308, PO Box 188061
Chattanooga, TN 37422-8061

Benefits are not insured by Cigna or affiliates

cigna healthcare Shared Administration PPO
MultiPlan Access may vary AWAY FROM HOME CARE

Member Services	1-833-448-2042 (TTY: 711)
Behavioral Health Benefits and Appointments	1-833-996-2567 (TTY: 711)
24/7 Nurse Advice Line	1-800-893-5597 (TTY: 711)
24/7 Virtual Doctor Appointment	www.teladoc.com

Blue and Gold:



health net

Member FIRST MI LASTNAME
Subscriber FIRST M LASTNAME
Effective Date 01/01/2025
Group Name UNIVERSITY OF CALIFORNIA
Group # 70189A
Plan MFC WITH PHARMACY

UC BLUE & GOLD HMO
Member ID # [XXXXXXXXXXX]

Medical Group and PCP
Canopy Health/Dignity Health MN–Santa Cruz
1-831-465-7800
Effective date with PPG: 01/01/2021

Dr. Martin Short
4747 Buena Vista St.
Burbank, CA 91505-7865
1-818-773-4433

In case of emergency call 911

PCP Visit	$30	ER	$125
Preventive Care	$0		
Urgent Care	$30		

Deductibles	In-Network	Out-of-Network
One Member	N/A	N/A
Family	N/A	N/A

Out of Pocket Max	In-Network	Out-of-Network
One Member	$1000	N/A
Family	$3000	N/A

healthnet.com/uc

Member Services	1-800-539-4072 (TTY: 711)
Behavioral Health Benefits and Appointments	1-800-663-9355 (TTY: 711)
Chiropractic & Acupuncture Services	1-800-678-9133 (TTY: 711)
24-hour Nurse Advice Line	1-800-893-5597 (TTY: 711)
24/7 Virtual Doctor Appointment	www.teladoc.com

Provider Services 1-800-641-7761
To report, or request approval for, inpatient admits, call: 1-800-995-7890
Pharmacy Help Desk 1-800-600-0180
RxBIN #004336 RxPCN HNET Processor Caremark

Claims Inside California – Health Net Claims - **Payer ID** 95567
PO Box 9040 Farmington, MO 63640-9040

Claims Outside of California (emergency and urgent care)
Cigna Medical Claims - **Payer ID** 62308 - PO Box 188061
Chattanooga, TN 37422-8061

Health Net of California, Inc. provides the health benefits under this plan

cigna healthcare Shared Administration PPO
Benefits are not insured by Cigna or affiliates
MultiPlan Access may vary AWAY FROM HOME CARE

Participating Physicians

Canopy Health IPAs/Medical Groups

Canopy Health has contracted with premier IPA/Medical Groups in the San Francisco Bay Area: Hill Physicians Medical Group, John Muir Health Physicians Network, Providence Medical Network, Santa Clara County IPA and Dignity Health Medical Network - Santa Cruz. There are approximately 6500 physicians in the Canopy Health network with offices in Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Sonoma and Solano.

Contact information for Canopy Health participating IPA/Medical Groups is provided below:

IPA/MEDICAL GROUPs	Customer Service Telephone Numbers	Websites
Hill Physicians Medical Group	(800) 445-5747 TTY to Voice: 1-800-735-2929 Voice to TTY: 1-800-735-2922	https://www.hillphysicians.com/
John Muir Physician Network	(925) 952-2887 or toll free (844) 398-5376 TDD/TTY: 711	https://www.johnmuirhealth.com/
Santa Clara County IPA	(800) 977-7332 TDD/TTY: 711	http://www.sccipa.com
Dignity Health Medical Network-Santa Cruz	(831)465-7800 TTY: (866) 660-4288	https://www.dignityhealth.org/dhmf/about/dhmn/santa-cruz https://portal.dignityhealthmso.org/mcsonline/mcso_login/login.aspx
Providence Medical Network	(800) 627-8106	https://www.providence.org

Policies and procedures related to quality and utilization management, professional billing and claims, and clinical health services are available at Canopy Health's participating Medical Groups' and IPAs' websites and directly through customer service at the respective provider groups.

Selection and Role of the Primary Care Physician in HMO Plans

All Canopy Health HMO members are required to select a primary care physician (PCP) and a participating IPA/Medical Group at the time of enrollment. For children, a pediatrician or family medicine physician may be designated as the primary care physician. For women, an

obstetrician/gynecologist ("OB/GYN") may serve as the designated primary care physician if the OB/GYN agrees to serve in that capacity. Additionally, seniors may designate a gerontologist and those with an AIDS/HIV diagnosis may designate an AIDS/HIV specialist as their primary care physician if that physician agrees to serve in that capacity. If a member does not choose a PCP, the Canopy Health participating health plan will assign a PCP for the member and their dependents. To change the designated primary care physician, members are required to contact their health plan.

Canopy Health HMO members may choose a PCP based on proximity to either their home or work address. Members are required to visit their primary care physician for non-urgent or non-emergency care.

The PCP is responsible for providing and coordinating medical care for their patients, including referrals to specialists, hospitals and other healthcare providers anywhere in the Canopy Health Network.

Specialty Care

Canopy Health provides a comprehensive alliance of physician specialists, available in locations throughout the Bay Area. These specialties include but are not limited to:

- Allergy and Immunology
- Bariatric surgery
- Breast Center
- Cardiology
- Cardiothoracic Surgery
- Colorectal Surgery
- Critical Care Medicine
- Dermatology
- Ear, Nose and Throat
- Endocrinology
- Gastroenterology
- General Surgery
- Gynecologic Oncology
- Hematology/Oncology
- HIV/AIDS Specialist
- Hyperbaric oxygen
- Infectious Disease
- Nephrology
- Neurology
- Neurosurgery
- Obstetrics/Gynecology
- Ophthalmology
- Orthopedic Surgery
- Pain Management
- Palliative Care
- Perinatology
- Physical Medicine (PMR)
- Plastic surgery
- Podiatry
- Pulmonary Disease
- Radiation Oncology
- Reproductive Endocrinology and Fertility
- Rheumatology
- Urology
- Vascular Surgery
- Wound Care

Canopy Health PCPs refer members for specialty services when clinically appropriate, choosing a participating Canopy Health specialist. Such referrals for HMO members are entered in each IPA/Medical Group's authorization system. Referrals for some specialty care require prior authorizations. Additional details regarding the Canopy Health Referral Policy are covered in the next section.

Lab Services

Canopy Health Physicians should refer members to the laboratory designated by the primary care physician's IPA/Medical Group for all products:

Member's IPA/Medical Group	LabCorp	Quest Diagnostics
Hill Physicians		X
John Muir Physician Network	X	
Providence Medical Network	X	X
SCCIPA	X	
Dignity Health Medical Network – Santa Cruz		X

Canopy Health Referral Policy

Physicians within the following IPA/Medical Groups participate in the Canopy Health Alliance and may refer to any provider in the Alliance: John Muir Health Physician Network, Hill Physicians Medical Group (San Francisco, San Mateo, Alameda, Contra Costa, Marin, Sonoma and Solano), Providence Medical Network, Dignity Health Medical Network Santa Cruz and Santa Clara County IPA.

Canopy Health members being referred within each IPA/Medical Group remain governed by the policies and procedures of that IPA/Medical Group. Canopy Health members referred to Canopy Health specialists outside their home IPA/Medical Group are governed by the policies and procedures defined by Canopy Health. Where there is a conflict between the policies of the IPA/Medical Group and the Canopy Health Alliance Referral Program, the Canopy Health Alliance Referral Program shall take precedence for Canopy Health enrollees. [Canopy Health Policies UM-004, UM-008]

Both physicians and members may request referral to a specialist, either within the member's home IPA/Medical Group or elsewhere in the Canopy Health alliance. When clinically appropriate, the requesting physician initiates a written or electronic referral that is entered in the member's home IPA/Medical Group authorization system. Such a request will be auto adjudicated when it meets the Canopy Health Alliance Referral Program policy, including "standing referrals" to specialists who provide ongoing care. [Canopy Health Policy UM-010]. Approved authorizations prompt standard notification to both the member and the "referred to" specialist and include details of the referral such as the number of visits, services approved and the time frame before the referral expires. [Canopy Health Policy UM-009].

On a quarterly basis, Canopy Health will report on Canopy Health Alliance Referral Program activity, using Medical Group or IPA encounter data. The review will include volume of visits and utilization of lab, urgent care, specialties, etc. The review will also study trends in members' selection of PCPs, to track potential correlation between PCP changes and members having sought care outside their initially assigned IPA/Medical Group.

Alliance Referral Program Overview

- Allows members to see any Canopy Health Network doctor, including an OB/GYN doctor, for medically necessary care. The member's Primary Care Physician (PCP) submits an authorization request to his/her UM department so the UM department can review and approve.

- Allows members to receive care from ancillary providers like physical therapy from any provider in the Canopy Health Network. The member's PCP submits an authorization request to his/her UM department so the UM department can authorize the visit.

- Lab testing is not included in this program so any medically necessary tests should be completed by the member's IPA/Medical Group's contracted laboratory.

7 Easy Steps to Use the Alliance Referral Program

1. Member and doctor decide on the Canopy Health specialist
2. The doctor's office submits an authorization request to Member's IPA/Medical Group
3. The UM department staff issues an authorization for 1 consultation and 2 follow up visits
4. The UM department notifies the member and the doctors of the authorization
5. The specialist sees the member
6. The specialist's office bills the Member's IPA/Medical Group
7. The Member's IPA/Medical Group pays the specialists at the Canopy Health reciprocity rate

Questions about the Alliance Referral Program should be directed to CHAlliancereferrals@CanopyHealth.com

Behavioral Health Access, Triage and Referral

Canopy Health is not delegated to provide or oversee behavioral health specialty services for its members. These services are provided by a vendor contracted directly with a member's health plan or employer. [Canopy Health Policy UM-003]
Behavioral health is offered through the following networks for Canopy Health members, based on the member's Health Plan and product.

Health Plan and Product	Behavioral Health Carrier	Phone Number
Health Net	MHN	(800) 663-9355
United Healthcare	Optum Behavioral Health	(800) 333-8724

Behavioral health provider networks and delegated plans must follow DMHC policies and procedures, including but not limited to:

- Providing a telephone intake system for members, which is staffed by trained personnel who are either individually licensed mental health professionals, or are supervised by a licensed mental health professional, and who provide or facilitate appropriate crisis intervention and initial referrals to mental health providers;

- Maintaining policies and procedures and/or training that define protocols for initial referrals to mental health providers;

- Ensuring member access to a behavioral health delivery system through a centralized triage and referral system. This is provided through the member's health benefit plan. Protocols for mental health triage and referral address the level of urgency and appropriate level of care relative to the member's mental status and level of functioning;

- Establishing standards and goals for the timeliness of response to its triage and referral telephone lines and measuring performance against those standards; and

- Ensuring that only qualified licensed clinical staff members make decisions about the type and level of care to which members are referred.

Canopy Health does not require prior authorization for the provision of emergency services and care to a patient with a psychiatric emergency.

Canopy Health's Partner Hospitals

Canopy Health members requiring non-emergent/non-urgent inpatient services may obtain these services at any Canopy Health contracted hospital where their Canopy Health attending physician has hospital privileges or has arranged for hospital coverage through hospitalists or another physician. Prior authorization is required for non-emergent/non-urgent admissions to acute or post-acute health care facilities. This process is discussed in more detail in the Utilization Management section of this manual. Care management and discharge planning is a collaborative process between the member's treating physician, the inpatient facility, the member's IPA/Medical Group and the Canopy Health clinical team.

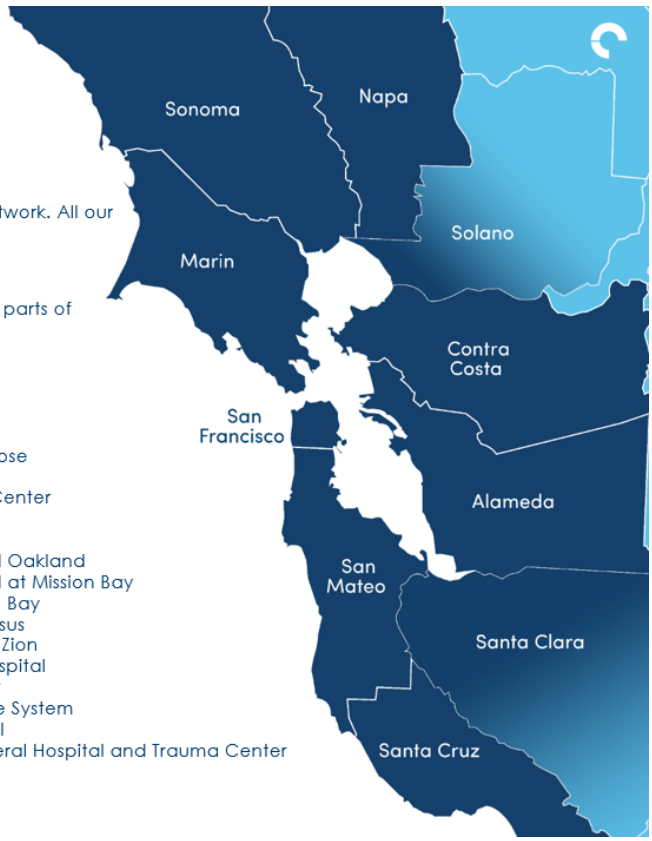
Hospitals and Contact Information

The Canopy Health Commercial Service Area

We've got the Bay Area covered.

Our Medical Groups allow referrals to each other's specialists, creating a single integrated network. All our doctors, hospitals, and care centers are at your service – no matter where you live or work.

- Dignity Health Medical Network – Santa Cruz
- John Muir Health Physician Network – Alameda, Contra Costa & partial Solano*
- Hill Physicians Medical Group – Alameda, Contra Costa, Marin, San Francisco, San Mateo, parts of Sonoma & Solano*
- Santa Clara County IPA (SCCIPA) – Santa Clara**
- Providence Medical Network – Sonoma and Napa



Hospitals

1. AHMC Seton Medical Center
2. AHMC Seton Medical Center Coastside
3. Alameda Hospital
4. Chinese Hospital
5. Dignity Health Dominican Hospital
6. Dignity Health Sequoia Hospital
7. Good Samaritan Hospital
8. Healdsburg Hospital
9. Highland Hospital
10. John Muir Medical Center, Concord
11. John Muir Medical Center, Walnut Creek
12. MarinHealth Medical Center
13. Petaluma Valley Hospital
14. Providence Queen of the Valley Medical Center
15. Providence Santa Rosa Memorial Hospital
16. Regional Medical Center San Jose
17. San Leandro Hospital
18. San Ramon Regional Medical Center
19. Sonoma Valley Hospital
20. St. Rose Hospital
21. UCSF Benioff Children's Hospital Oakland
22. UCSF Benioff Children's Hospital at Mission Bay
23. UCSF Medical Center at Mission Bay
24. UCSF Medical Center at Parnassus
25. UCSF Medical Center at Mount Zion
26. UCSF Saint Francis Memorial Hospital
27. UCSF St. Mary's Medical Center
28. Washington Hospital Healthcare System
29. Watsonville Community Hospital
30. Zuckerberg San Francisco General Hospital and Trauma Center

* Solano County zip codes: 94591 and 94510

** Health Net B&G does not include Napa, Santa Clara and parts of Sonoma County

AHMC Seton Medical Center
1900 Sullivan Avenue, Daly City, CA 94015
650-992-4000
https://setonmedicalcenter.com/

AHMC Seton Medical Center Coastside
600 Marine Blvd, Moss Beach, CA 94038
650-563-1700
https://setonmedicalcenter.com/

Alameda Hospital
2070 Clinton Avenue, Alameda, CA 94501
510-522-3700
http://www.alamedaahs.org

Chinese Hospital
845 Jackson Street, San Francisco, CA 94133
415-982-2400
https://www.chinesehospital-sf.org/

Dignity Health Sequoia Hospital
170 Alameda de las Pulgas, Redwood City, CA 94062
855.900.4062
https://www.dignityhealth.org/bayarea/locations/sequoia

Dignity Health Dominican Hospital
1555 Soquel Dr. Santa Cruz, CA 9406
866-226-8361
http://www.dignityhealth.org

Good Samaritan Hospital
2425 Samaritan Drive, San Jose CA 95124
408-559-2011
https://www.goodsamsanjose.com

Healdsburg Hospital
1375 University Street, Healdsburg, CA 95448
707-431-6500
https://healdsburgdistricthospital.org/

Highland Hospital
1411 E 31st Street, Oakland, CA 94692
510-437-4800
http://www.highlandahs.org/

John Muir Medical Center, Concord
24 East Street, Concord, CA 94520
925-682-8200
https://www.johnmuirhealth.com/locations.html

John Muir Medical Center, Walnut Creek
1601 Ygnacio Valley Road, Walnut Creek, CA 94598
925-939-3000
https://www.johnmuirhealth.com/locations.html

MarinHealth Medical Center
250 Bon Air Road, Greenbrae, CA 94904
415-925-7000
https://www.mymarinhealth.org/

Petaluma Valley Hospital
400 N. McDowell Blvd, Petaluma, CA 94954
707-778-1111
https://www.providence.org/locations/norcal/petaluma-valley-hospital

Providence Queen of the Valley Medical Center
1000 Trancas Street, Napa, CA 94558
707-252-4411
https://www.providence.org/locations/norcal/queen-of-the-valley

Providence Santa Rosa Memorial Hospital
1165 Montgomery Drive, Santa Rosa, CA 95405
707-525-5300
https://www.providence.org/locations/norcal/santa-rosa-memorial-hospital

Regional Medical Center of San Jose
225 N Jackson Avenue, San Jose CA 95116
408-259-5000
https://www.regionalmedicalsanjose.com

San Leandro Hospital
13855 East 14th Street, San Leandro, CA 94578
510-357-6500
http://www.sanleandroahs.org/

San Ramon Regional Medical Center
6001 Norris Canyon Road, San Ramon, CA 94583
925-275-9200
https://www.sanramonmedctr.com/

Sonoma Valley Hospital
347 Andrieux Street, Sonoma, CA 95476
707-935-5000
https://www.sonomavalleyhospital.org

St. Rose Hospital
27200 Calaroga Avenue, Hayward, CA 94545
510-264-4000
https://www.strosehospital.org

UCSF Benioff Children's Hospital Oakland
747 52nd Street, Oakland, CA 94609
510-428-3000
http://www.childrenshospitaloakland.org/main/maps-locations/20.aspx

UCSF Benioff Children's Hospital at Mission Bay
1975 Fourth Street, San Francisco, CA 94158
415-353-1664
https://www.ucsfbenioffchildrens.org/

UCSF Medical Center at Mission Bay
1855 Fourth Street, San Francisco, CA 94158
415-353-1664
https://www.ucsfhealth.org/

UCSF Medical Center at Mount Zion
1600 Divisadero Street, San Francisco, CA 94115
415-353-1000
https://www.ucsfhealth.org/locations/mount-zion

UCSF Medical Center at Parnassus
505 Parnassus Avenue, San Francisco, CA 94117
415-476-1000
https://www.ucsfhealth.org/

UCSF Saint Francis Memorial Hospital San Francisco
900 Hyde St., San Francisco, CA 94109
415-363-6000
https://sfcommunityhospitals.ucsfhealth.org/saint-francis

UCSF St. Mary's Medical Center
450 Stanyan St, San Francisco, CA 94117
415-668-1000
https://sfcommunityhospitals.ucsfhealth.org/st-marys

Washington Hospital Healthcare System
2000 Mowry Avenue, Fremont, CA 94538
510-797-1111
http://whhs.com/

Watsonville Community Hospital
75 Nielson Street, Watsonville, CA 95076
831-763-6040
https://watsonvillehospital.com/

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue, San Francisco, CA 94110
628-206-8000
https://zuckerbergsanfranciscogeneral.org

Repatriation from Non-Contracted Hospital

If a Canopy Health member is admitted to a non-contracted facility, that member may be considered for repatriation to a Canopy Health facility. Such a transfer may take place only when these circumstances apply:

- The member has been medically stabilized
- The transferring and receiving health care providers determine that no material clinical deterioration of the member is likely to occur during or upon transfer
- The transferring and receiving health care providers believe that further inpatient health care treatment is medically necessary; and
- The member cannot safely be discharged home.

If a Canopy Health member cannot obtain non-emergent/non-urgent medically necessary inpatient services at a Canopy Health facility, the member's physician may refer the member to a non-contracted facility and the IPA/Medical Group Utilization Management staff may approve services at a non-contracted facility that can offer such care. Prior authorization and medical review are required for non-emergent/non-urgent inpatient services at non-contracted facilities. [Canopy Health Policy QM-009]

Emergency Services

Emergency services and care means medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. Emergency services and care also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility. The care and treatment

necessary to relieve or eliminate a psychiatric emergency medical condition may include admission or transfer to a psychiatric unit within a general acute care hospital (as defined in subdivision (a) of Section 1250), or to an acute psychiatric hospital (as defined in subdivision (b) of Section 1250, pursuant to subdivision (k)). Nothing in this subparagraph shall be construed to permit a transfer that is in conflict with the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code).

All Emergency Services are covered without prior authorization and do not require medical record review. These requests cannot be denied for failure to obtain a prior approval when approval would be impossible, e.g., the member is unconscious and in need of immediate care, or where a prior approval process could reasonably be expected to result in any of the following: 1) placing the member's health in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part at the time medical treatment is required.

In the Canopy Health service area, Canopy Health shall pay for all medically necessary facility services provided to a member who is admitted through the emergency room until the member's condition is stabilized. All requests for authorizations of medically necessary health care services after stabilization and all responses to such authorization requests will be fully documented in the Utilization Management tracking system of the member's IPA/Medical Group. Treating physicians will document provision of all medically necessary health care services in their usual medical record.

When Canopy Health or a contracted health plan (i.e., Health Net) denies requests for authorization of post stabilization medical care at outside facilities and elects to transfer a member to another health care provider, the following applies:

- A physician or other appropriate practitioner reviews presenting symptoms and discharge diagnoses for emergency services. The IPA/Medical Groups may not restrict emergency medical conditions based on lists of diagnoses or symptoms. Behavioral health care practitioners are available to review psychiatric emergency conditions. [Canopy Health Policy UM AER-001]. Canopy Health or a contracted health plan shall inform the treating provider of the decision to transfer the member to another health care provider
- The IPA/Medical Group shall effectuate the transfer of the member as soon as possible

The emergency screening fee (Medical Screening Exam) will be paid in a timely fashion by the responsible party (i.e., the IPA/Medical Group, Canopy Health, or health plan) for all ER claims when clinical data that would support a higher level of payment is not available. The IPA/Medical Groups have processes to review and address claims payment and provider disputes about emergency room claims that have been denied.

Non-contracted providers are paid for the treatment of the emergency medical condition, including medical necessary services rendered to a member, until the member's condition has stabilized sufficiently to permit discharge or referral and transfer to a contracted facility.

Ambulance services are covered when the member reasonably believed the condition was an emergency.

Out of Area Emergency Services

Emergency and urgent services are covered when a member is temporarily out of the service area and requires immediate medically necessary healthcare because 1) the illness, injury, or condition was unforeseen; and 2) it was not reasonable for the member to obtain the services through Canopy Health providers given the circumstances. Members are responsible for payment of copays and/or coinsurance per their specific benefit plan but can never be balance-billed for emergency services.

Under unusual and extraordinary circumstances, services may be considered urgently needed when they are provided within the service area by a non-Canopy Health provider when a Canopy Health provider is unavailable or inaccessible.

The health plans handle the utilization management of out of area emergency services and emergency admissions. Please see member's ID card for health plan contact information.

Ancillary Providers and Services

Canopy Health has a network of ancillary providers throughout the San Francisco Bay area. Canopy Health members may access contracted ancillary providers with a physician referral. Prior authorization is not required for many services including the following ancillary services but please check your IPA/Medical Group website for a list of all services that require prior authorization.

- Urgent care centers
- Routine laboratory tests (In Network)
- Diagnostic imaging: plain x-rays and non-contrast ultrasound
- Emergency services
- Basic prenatal care
- Family planning services
- Sexually transmitted disease services
- Preventive services
- HIV testing
- Involuntary psychiatric inpatient admission
- Self-referral for behavioral health

Provider Directory and Online Access

The Canopy Health Provider Directory ("Directory") includes providers currently contracted with Canopy Health. This Directory is available to Canopy Health members, health care providers and the public without any restrictions or limitations. All Canopy Health enrollees receive full and equal access to covered services, regardless of disability, as required by the Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973. Member questions and concerns should be directed to the member's Health Plan number located on the back of the card.

Online Provider Directory

The online Directory is available at www.canopyhealth.com. It is easy to navigate and the various sections corresponding to the printed Directory are easily identifiable. Members may want to see all the options in a specific searchable field to maximize accuracy and the probability of finding results through a single search query. For example, members can scroll through a drop-down box to see all specialties before they choose a specialty for their query. Where free text entry for a field makes more sense, this option is offered (such as zip code).

Printed Provider Directory

The printed version of the Canopy Health Provider Directory contains the same information available through the online Directory, organized into the following primary sections listed below. To request a printed copy of this directory, members and providers may call 1-888-8 CANOPY TDD/TTY For the hearing-impaired California Relay Service (CRS) 711 or (800) 855-7100 or log into www.canopyhealth.com, or send a written request to: Canopy Health, 2100 Powell Street, Suite 600, Emeryville, CA 94608.

Printed Provider Directory Sections:

1. About Canopy Health
2. Choosing a Physician
3. Request a Referral
4. Key Contacts
5. Physician Profiles
6. Acute Care Facilities listing
7. Ancillary Facility listing

This same information may be accessed at www.canopyhealth.com. The online information may be organized slightly differently to facilitate fast and intuitive provider searches.

Provider Directory Updates

Canopy Health meets DMHC requirements for updating, maintaining, and ensuring accuracy of the provider profiles in its Directory. Updates to the Directory occur weekly in the online version of the Directory and quarterly in the printed version.

Canopy Health's alliance IPA/Medical Groups provide weekly Directory updates to Canopy Health. Contracted providers must notify their IPA/Medical Group within five (5) business days of status change, such as if they start or stop accepting new patients. The weekly update of the Directory includes changes to the following:

- Demographic information including name, address, phone number, email address
- If the provider is accepting new patients
- Any change of participation in a health plan or product
- Hospital affiliation
- Group practice membership
- Specialty certification or license status
- If the provider becomes inactive or retires
- Any other information with a material effect on the content or accuracy of the Directory

The weekly update will also include information received during investigations prompted by a member's or provider's report of an inaccuracy in the Directory. Weekly updates also delete providers from the Directory if they are no longer contracted with the plan, no longer seeing patients, have retired from clinical practice, or experienced other changes impacting their ability to serve as a contracted provider.

Reports of Inaccuracy and Plan Investigation

Canopy Health provides a clearly identifiable and user-friendly means for providers and members to report inaccuracies in the Directory. Canopy Health has a process to allow both members and healthcare providers to notify Canopy Health about potential inaccuracies in the Directory. All reported inaccuracies are investigated promptly, and changes or corrections are updated through the participating IPA/Medical Group and then weekly online and quarterly in the printed directory. Providers are contacted within five (5) days of a reported inaccuracy. Corrections required will be completed within thirty (30) days of being reported. Required changes to the Directory are entered during the next weekly update. Canopy Health documents receipt of the reported inaccuracy, investigative process and outcome of all investigations. Members who find an inaccuracy in the Directory have three options to report the potential error to Canopy Health:

1. By completing an online form on Canopy Health's website (www.canopyhealth.com), which generates an email that is sent directly to the Canopy Health Network Development Team
2. By telephone: 1-888-8CANOPY TDD/TTY for the hearing-impaired California Relay Service (CRS) 711 or (800) 855-7100.
3. By mail: sending notice to the Canopy Health Network Development Team at 2100 Powell Street, Suite 600, Emeryville, CA 94608.

Members who complete the online form receive an immediate acknowledgement that their report has been received. If the member reports that a physician is no longer accepting new patients, they should be referred to their health plan's member service center using the number listed on the back of their ID card. All reports are tracked, monitored and reported to the Quality Management Committee. [Canopy Health Policy UM/GA 001]

Providers who wish to report an inaccuracy or to make a change to their existing profile in the Directory may do so by contacting their IPA/Medical Group's credentialing department.

Provider Obligations and Plan Oversight

If a Canopy Health member contacts a provider seeking to become a new patient and that provider is not accepting new patients, the provider will direct the patient to the health plan. Any provider not accepting new patients will contact the IPA/Medical Group listed on the member's ID card to request that their practice be closed to new members.

In all provider agreements, IPA/Medical Group will include a stipulation that if a contracted provider is no longer accepting new patients, or if the provider was previously not accepting new patients, but is currently accepting new patients, the provider is required to notify IPA/Medical Group within five (5) business days.

Claims Submission Information

See Claims Submission Quick Reference Guide in the Appendix

Encounter Data Submission (HMO)

All Canopy Health contracted IPA/Medical Groups are contractually obligated to provide encounter data in a data file format determined by Canopy Health. Encounter data is to be submitted monthly to the member's upstream health plan, as well as to MedPOINT Management (MPM). Encounter data is used for regulatory compliance reporting and performance evaluation of the Canopy Health alliance. For information on submission of data files, contact Canopy Health Provider Services at 800-898-1016.

Filing a Claim

Canopy Health is delegated to pay facility and ancillary provider claims for the HMO Products indicated in this Provider Manual. Canopy has contracted with MedPOINT Management (MPM) to perform the claims processing on their behalf. Professional claims will continue to be processed by the participating Medical Groups and/or their respective vendors.

- Providers are encouraged to file claims electronically whenever possible. Submitted claims should provide all required information; those submitted with missing data may result in a delay in processing or denial.
- Canopy Health Website – www.canopyhealth.com provides general information and a link to the MedPOINT Management (MPM) website for claims, and to participating provider's websites.
- MedPOINT Management (MPM) Website: https://portal.medpointmanagement.com/sign-in
- This portal provides access to query and view status on facility claims, eligibility status, contracted providers, and other important information.

Electronic Claims Submission

Canopy Health, through MedPOINT Management (MPM), its Managed Service Organization ("MSO"), contracts with the vendors listed below for submission of electronic claims. Additional clearinghouses/vendors may also submit using these channels. The benefits of electronic claim submission include:

- reduction or elimination of costs associated with printing and mailing paper claims
- improvement of data integrity using clearinghouse edits
- faster receipt of claims by Canopy Health, 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

Clearinghouse	Payer ID
Office Ally	MPM71
Change Healthcare	CNPY1

Electronic Data Interchange (EDI) questions

For questions regarding electronic claim submission, please call MedPOINT Management (MPM) at 800-898-1016. MedPOINT Management (MPM) Provider Services Department is open Monday – Friday 9:00 a.m. -5:00 p.m. PST.

Paper Claims Submission and MPM Contact Information

- Paper Claim Submissions P.O. Box 7020-26 Tarzana, CA 91357
- Appeals & Provider Disputes P.O. Box 7020-26 Tarzana, CA 91357
- Claims Department Phone 800-898-1016
- All Other Provider Inquiries 800-898-1016

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA):

Canopy Health, in partnership with MPM, is pleased to offer providers the opportunity to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) services. Through our collaboration with Zelis, this new digital payment solution streamlines claims payments, enhances security, and provides faster, more efficient access to your payment information. Beginning January 1, 2026, all payments will be received via your preferred Zelis delivery method. Should you have any questions regarding Zelis, please call 855-774-4392.

Clean Claim Guidelines

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

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

- duplicate submission
- member is not eligible for date(s) of service(s) ("DOS")
- incomplete data
- non-covered services

Timely Filing Guidelines for Commercial Plans

California Code of Regulations Title 28 Rule 1300.71 provides claims submission timelines for Commercial claims as follows:

- Contracted Providers: Billing Limitation – within 90 calendar days (3 months) from the Date of Service (DOS). Refer to each provider's contract for variations in the claims filing limit.
- Non-Contracted Providers: Billing Limitation – within 180 calendar days (6 months) from the Date of Service (DOS).

Corrected Claims

Providers must correct and resubmit claims to Canopy Health within the 12-month clean claim time frame. When resubmitting a denied claim, the provider must submit a new claim containing all previously submitted lines. The original claim reference number from the remittance advice ("RA") must be included on the CORRECTED claim to identify the resubmitted claim. If the original claim reference number is missing, the claim may be entered as a new claim and denied for being submitted beyond the initial submission time frame. Corrected claims must be appropriately marked as such and submitted to the appropriate claims electronic processor or mailing address.

- Professional claims submitted on a **HCFA 1500** must include a resubmission code of "7" with the original claim number in box 22 of a paper claim. EDI 837P data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an additional loop in the 2300 loop, segment REF*F8* with the original claim number for which the corrected claim is being submitted.
- Facility claims submitted on a **UB04** must be identified by the type of bill submitted as ** XX7 – The bill type ending in a "7" indicates the claim is a corrected claim, the original claim number should be listed in box 64 on a paper claim. EDI 837P data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an additional loop in the 2300 loop, segment REF*F8* with the original claim number for which the corrected claim is being submitted.

Balance Billing

Balance billing is the practice of a participating provider billing a member for the difference between the contracted amount and billed charges for covered services. When participating providers contract with Canopy Health, they agree to accept Canopy Health's contracted rate as payment in full. Billing members for any covered services above and beyond the contracted rate is a breach of contract. Participating providers may only seek reimbursement from Canopy Health members for appropriate cost-share amounts, including copayments, coinsurance, and/or deductibles.

AB72 is the "surprise billing" legislation that establishes a payment rate for Commercial health plan members, which is the greater of the average of a health plan's contracted rate, as specified, or 125% of the amount Medicare reimburses for the same or similar services; and an independent dispute resolution process (IDRP) for claims and claim disputes related to covered services provided at a contracted health facility by a non-contracting individual health care professional. This legislation applies to all health plan contracts and health policies issued, amended, or renewed on or after July 1, 2017. This legislation limits member and insured cost sharing for these covered services to no more than the cost sharing required had the services been provided by a contracting health professional.

Guidelines for billing Canopy Health Commercial members are listed as follows:

- Providers may bill a Canopy Health member when the member knowingly receives non-covered services. The provider must notify the member in advance of the charges and have the member sign a statement agreeing to pay for the services. This signed document should be entered into the member's medical record.
- Canopy Health members must not be balance billed or reported to a collection agency for any covered service that has been provided.
- Providers may not charge members for services that are denied or reduced due to the provider's failure to comply with billing requirements, such as timely filing, lack of authorization or lack of clean claim status.
- Providers must not collect copayments, coinsurance or deductibles from members with other insurance such as Medicare or another commercial carrier.

Member Financial Responsibility

Canopy Health members are responsible for co-pays or coinsurance as determined by their individual employee benefit plan.

Canopy Health providers agree to accept payment per their contract as payment in full. Balance billing for the difference between the contracting amount and billed charges for covered services is prohibited and is considered a breach of contract, as well as a violation of the PPA and state and federal (ARS 20-1072) statutes. In some instances, balance billing of members can result in civil penalties as stated in ARS 36-2903.01(L).

Coordination of Benefits

Coordination of benefits ("COB") is required before submitting claims for members who are covered by one or more health insurers other than their primary health plan. Canopy Health follows the applicable regulations regarding coordination of benefits between both commercial and government insurance products.

Participating providers are required to administer COB according to the applicable regulations. The participating provider should ask the member about coverage through another health plan and enter that other health insurance information on the claim.

Providing COB Information

For Canopy Health to document member records and process claims appropriately, include the following information on all COB claims submitted to Canopy Health:

- name of the other carrier
- subscriber ID number with the other carrier including contact information, primary subscriber, or preferably, a COB form from the provider.

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

- File the claim with the primary carrier, as determined by the applicable regulations.
- After the primary carrier has paid, attach a copy of the Explanation of Payment (EOP) or Explanation of Benefits (EOB) to a copy of the claim and submit both to Canopy Health within 90 days from the date of payment from the primary carrier. COB claims can also be submitted electronically with the details from the other payer ERA appropriately submitted in the 837 transaction COB loops. If the primary carrier has not made payment or issued a denial, submit the claim to Canopy Health within 90 days from the date of contest, denial or notice from the primary payer. If denied based on timeliness, the claims are treated as non-reimbursable, and the member cannot be billed.

COB Payment Calculations

Canopy Health coordinates benefits and pays balances, up to the member's liability, for covered services. However, in cases where Canopy Health is not the primary payer, the dollar value of the balance payment cannot exceed the dollar value of the amount that would have been paid had Canopy Health been the primary payer.

In some 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.

Overpayments

Canopy Health makes every attempt to identify a claim overpayment and indicate the correct processing of the claim on the provider's Remittance Advice (RA). When Canopy Health identifies an overpayment a refund request letter will go out to the provider. Provider can return the payment with a copy of the refund request letter or dispute the overpayment in writing. Provider must refund or dispute within 30 working days of receiving notice of overpayment. Overpayments may be offset against future payments if allowed in providers contract.

If a provider independently identifies an overpayment from Canopy Health (such as a credit balance), the following steps are required to be taken by the provider:

- Send the overpayment refund and applicable details to:

Canopy Health
c/o MedPOINT Management (MPM)
P.O. Box 7020-26
Tarzana, CA 91357

Include a copy of the RA that accompanied the overpayment to expedite Canopy Health's adjustment of the provider's account. It takes longer for Canopy Health to process the

overpayment refund without the RA. If the RA is not available, the following information must be provided:

- member name and Canopy Health member ID number
- date of service
- payment amount
- vendor name and number
- provider tax ID number
- reason for the overpayment refund

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

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

Additional Information

If you have additional questions, please contact the Canopy Health Provider Services Center at 800-898-1016, Monday – Friday 9:00 a.m. – 5:00 p.m. Pacific Time with questions regarding third-party recovery, coordination of benefits or overpayments.

Provider Disputes (HMO)

Provider Disputes due to Claims Decisions

A provider dispute due to claims decision is a written notice from the provider to Canopy Health (sent to Canopy Health's claims administrator MedPOINT Management (MPM) that:

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

Providers should exhaust all claims processing procedures and follow the guidelines below before filing a claim dispute with Canopy Health:

- If the provider has not received a Claims Remittance Advice (RA) identifying the status of the claim, he or she should call the Canopy Provider Services to inquire whether the claim has been received and processed.
- Providers should allow 30 calendar days following claim submission before inquiring about a claim. However, providers should inquire well before six months from the date of service because of the time frame for initial claim submission and for filing a claim dispute
- If a claim is pending in the Canopy Health claims system, a claim dispute will not be investigated until the claim is paid or denied. A delay in processing a claim may be cause for a claim dispute on a pended claim provided all claim dispute deadlines are met (must be filed within 12 months of the last payment).

Past Due Payments

If the provider dispute involves a claim and the outcome is determined to be in favor of the provider, Canopy Health will pay any outstanding money due, including any required interest or penalties, within 15 business days of the date of the decision. When applicable, accrual of the interest commences on the day following the date by which the claim should have been processed (as noted below).

Claims Payment Turnaround Time Commercial

- Claims payment turnaround time is 30 calendar days. Refer to each provider's contract for variations in the claim's payment turnaround time.

Provider Dispute Time Frame Commercial

Disputes are accepted if they are submitted no later than 12 months from the date of the last payment. If the provider's contractual agreement provides for a dispute-filing deadline that is greater or less than 365 calendar days, the contract dispute filing deadline applies.

Provider Disputes due to Utilization Management (UM) Decisions

Commercial Member UM Decisions:

Pre-service Denial:

If an authorization has been denied and the service has not been provided, then the provider should request a reconsideration or peer-to-peer review from the member's IPA/medical group as described in the denial notice. If the reconsideration request is again denied, then the member or the provider may appeal this decision to either Health Net or United HealthCare as described in the denial letter.

Concurrent or Retrospective Denial:

If an authorization request is denied based on a UM Decision (for example, service is not medically necessary, or a denied day, or a denied admission, or a different level of care, or a wrong provider) for a service that requires prior authorization and has already been provided, the dispute must first be submitted for reconsideration to the member's IPA/Medical Group. If the authorization reconsideration request is denied by the IPA/Medical Group and the claim is denied, then the request may be submitted to Canopy Health in writing for further reconsideration as a provider dispute. The dispute must include a copy of all correspondence including letters from the member's physician(s), hospital and IPA/Medical Group UM department, and a copy of the pertinent member medical records.

Submitting Provider Disputes

- Providers should submit provider disputes on a Provider Dispute Resolution Request form. If the dispute is for multiple and substantially similar claims, a Provider Dispute Resolution Request spreadsheet should be submitted along with the form. Providers may download an electronic copy of the Provider Dispute Resolution Request form by visiting the MedPOINT Management (MPM) website https://www.medpointmanagement.com/

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

- If the dispute is regarding a claim or a request for reimbursement of an over or underpayment of a claim, the dispute must include a clear identification of the disputed item, the date of service, and a clear explanation as to why the provider believes the payment amount, request for additional information, request for reimbursement of an overpayment, or other action is incorrect.
- If the dispute is regarding a UM decision, the dispute must include a copy of all correspondence including letters from the member's physician(s) and IPA/Medical Group UM department, and a copy of the pertinent member medical records.

- If the dispute is about another issue, a clear explanation of the issue and the basis of the provider's position.
- If the provider dispute does not include the required submission elements as outlined above, the dispute is returned to the provider along with a written statement requesting the missing information necessary to resolve the dispute. The provider must resubmit an amended dispute along with the required missing information.
- Canopy Health does not discriminate or retaliate against a provider due to a provider's use of the provider dispute process. A provider claim dispute is processed without charge to the provider; however, Canopy Health has no obligation to reimburse any costs that the provider has incurred during the claim dispute process.
- Providers can send provider disputes to:

Canopy Health

c/o MedPOINT Management (MPM)

P.O. Box 7020-26

Tarzana, CA 91357

DMHC Appeal Rights for Services provided to Commercial Members

Once the provider has exhausted all provider dispute resolution and arbitration procedures, then provider has a right to request a provider fair hearing through the DMHC.

- Providers who are contracted with Canopy Health should submit their disputes to DMHC via their process detailed here: http://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan.aspx
- Providers who are not contracted with Canopy Health should use the Non-Emergency Services Independent Dispute Resolution Process (AB 72 IDRP) through DMHC, detailed here: http://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan/NonEmergencyServicesIndependentDisputeResolutionProcess.aspx

Provider Disputes-All Other Disputes

All other types of provider disputes between Canopy Health and Providers for which the agreement between Canopy Health and Provider does not specify specific procedures or timelines should be resolved, to the extent possible, by informal meetings or discussions between appropriate representatives of the parties. Providers may submit disputes to Canopy Health by emailing a detailed description of the dispute and any supporting documentation to chcontracting@canopyhealth.com. The parties will meet and confer within 30 calendar days of receipt to resolve the dispute. If the parties are unable to resolve the dispute within 60 days of the first meeting to discuss the dispute, then either party may provide written notification of their intent to proceed with arbitration or other dispute resolution process provided for in their Agreement with Canopy Health.

Health Plan Demand Process*:*

Canopy Health will work with dedicated/assigned representatives at Canopy Health's MSO and/or sub delegated IPAs/Medical Groups to timely resolve all Health Plan Demands. Canopy Health follows the following Health Plan Demand process:

- Upstream Health Plans send Health Plan Demands to Canopy Health's MSO, MedPOINT Management (MPM)
- MedPOINT Management (MPM)will track and trend issue and review against Canopy Health's DOFR to determine if provider issue is Canopy Health or IPA/MG risk
- If Health Plan Demands are not Canopy Health's risk, MedPOINT Management (MPM)will forward to the responsible IPA/Medical Group within 24 hours to allow IPA/Medical Group to complete request
- MedPOINT Management (MPM) and/or IPA/Medical Group will send completed response to Health Plan by Due Date and CC Canopy Health with the response
- Health Plan will send legal cases, complaints to the DMHC, or escalations to Canopy Health
- Canopy Health and sub delegated IPAs/Medical Groups are contractually required to adhere to the timeframe set by Health Plans
- In some instances, escalated requests may have shorter response time frames that must be adhered to in order to remain in compliance. Examples include but are not limited to: California Department of Managed Health Care or CMS complaints.

Member Grievances and Appeals

Canopy Health is not delegated by our Health Plans to review, process or manage member grievances or appeals. Health Plans shall be responsible for resolving all Member Grievances (complaints) or appeals of benefit or claims decisions. The Grievance and Appeals forms for each health plan are included in the Appendix to this Provider Manual. The forms can also be found on the Canopy Health website https://www.canopyhealth.com/grievances-and-appeals/

For Health Net Members

Members should contact Health Net in one of these ways:

Telephone: Customer Contact Center at 1-800-522-0088 and TTY 1-800-995-0852. or

Online: submit a grievance form through https://www.healthnet.com/content/healthnet/en_us/members/appeals-and-grievances.html or

By mail: file a complaint in writing to Health Net Appeals and Grievance Department, P.O. Box 10348, Van Nuys, CA 91410-0348.

For United Healthcare SignatureValue Advantage or SignatureValue Harmony Members

Members should contact United Healthcare in one of these ways:

Telephone: UnitedHealthcare Customer service at 1-800-624-8822 or

Online: Complete the Grievance Form for Managed Care Members found at

https://www.uhc.com/member-resources/forms

Submit forms by mail or fax: Attention: Appeals and Grievances Department, MS CA 124-0160, P.O. Box 6170, Cypress, CA 90630-9972 or by fax: 1-866-704-3420

Resolution Time Frame

Member Appeals and Grievances are handled by each health plan's grievance and appeals department within DMHC regulated timeframes following receipt of the grievance/appeal and a written determination will be provided.

Utilization Management

Prior Authorization for HMO Plans

Utilization management authorization decisions are conducted by the Utilization Management department of each of Canopy Health's IPA/Medical Groups. For clinical trials, out of area services, out of area emergency admissions and transplants, the health plan makes and communicates all authorization decisions.

Referrals for the following services require prior authorization by a participating Medical Groups/IPAs Utilization Management Departments or the health plans. The list below is not all inclusive and may vary depending on individual member's benefit plans.

See the following pages for Prior Authorization Requirements.

The following services require prior authorization.
Ambulance (BLS and CCT). Excluding interfacility transfers to a higher level of care or repatriation from an out-of-network facility to an in-network facility
Ambulatory Surgery. • SEE FOLLOWING PAGES FOR SPECIFIC AMBULATORY SURGERIES THAT REQUIRE PRIOR AUTH • OBS that is done with ambulatory surgery does not require separate auth.
Bariatric Surgery. Professional (if Canopy is financially responsible)
Inpatient (hospital, LTAC, SNF). Emergency room services do not require prior authorization but once the patient is stabilized authorization needs to be obtained for the remainder of the patient's stay. For maternity, inpatient stay does not need to be authorized in addition to the global maternity authorization.
Cosmetic Surgery. Facility & Prof (if Canopy is financially responsible) - see Cosmetic Codes
DME/Prosthetics/Orthotics. Excluding the following: • *Maternal health:* ▪ Breastfeeding pumps: E0602 - E0604 ▪ Breastfeeding pump supplies: A4285 - A4287 • *Mobility aids including standard manual wheelchairs, crutches, walking boots, and canes* ▪ Manual wheelchairs: K0001 – K0005, E1130 - E1161 ▪ Crutches: E0110 - E0116 ▪ Walking boots: L4360, L4361, L4386, L4387 ▪ Canes: E0100, E0105 • *Oxygen therapy equipment and respiratory equipment including CPAP/BiPAP and vent supplies:* ▪ Oxygen Therapy: E0424, E0425, E0430, E0431, E0431, E0433, E0434, E0439 ▪ CPAP: E0601 ▪ CPAP Supplies: A7030 - A7039 ▪ Bi-PAP: E0470, E0471 ▪ Bi-Pap Supplies: A7030 - A7039 • *Basic (non-custom) orthotics:* ▪ Basic (non-custom) Orthotics: L0112 - L4631 • *Ostomy and wound care supplies:* ▪ Ostomy: A4361 – A4438 ▪ Various Ostomy supplies: A5051 – A5093 ▪ Wound Care supplies: A6000 – A6208, A6250 - A6412 • *Enteral feeding and infusion therapy supplies:* ▪ Enteral Feeding & Infusion therapy supplies: B4034 – B9999 ▪ Enteral Formula & Additives: B4100 - B4162 • *Auditory implants, hearing aids:* ▪ Auditory Implants (Cochlear Implant): L9900

▪ Replacement of a complete external sound processor system: L8694 ▪ Cochlear Implant supplies (headset, microphone, transmitting coil, transmitter cable for use with cochlear implant device): L7510 ▪ Hearing Aids: V5120, V5130, V5140, V5150 • *Continuous glucose monitors and other diabetes supplies:* ▪ Continuous glucose monitor: E2102 ▪ Continuous glucose monitors supplies: A4233 – A4236, A4253, A4256, A4256, A4258, A4259, A4206, A8004, A9276, A4230 - A4232, A4238 – A4239 • *Diabetic supplies*: ▪ Insulin Pump: E0776 – E0791, J1817 ▪ Insulin Pump Supplies: A4206 – A4209, A4210-A4213, A4215, A4216 – A4218, A4220-A4226, A4230-A4239, A4244-A4248, A4250-A4259
Genetic Testing. Exception: no prior authorization required if done in conjunction with amniocentesis, HCPC 81420 or any cancer diagnosis listed below: • C00-D499- Neoplasms • Z08- Encounter for follow-up examination after completed treatment for malignant neoplasm • Z85-Z859- Personal History of malignant neoplasm
Home Health
Infused drugs, outpatient and office, excluding chemotherapy and adjunctive therapy
Injectables, therapeutics - outpatient and office. Excluding the following: • Steroids (for medical use) • Antibiotics • Analgesics • Local anesthetics • Intravenous fluids • Vaccines and immunizations • Antiemetics • Antihistamines • Epinephrine • Routine electrolyte replacement
Out of Network/Non-Par (For any non-emergency service)
PET Scans (if CH is financially responsible)
Radiation Therapy -- Limited to (see codes below): **· Intensity modulated radiation therapy (IMRT)** **· Neutron beam therapy** **· Proton beam therapy** **· Stereotactic radiosurgery and stereotactic body radiotherapy (SBRT)**

The following services do not require prior authorization as long as provided by a Canopy Health participating provider.
Fetal non stress test
Blood, blood products, storage, blood factors
Chemotherapy and adjunctive therapy (not including immunotherapy)
Colostomy supplies
Dialysis - including any infused drugs during dialysis
Emergency room visits
Emergency charges that are part of an emergency admission
Hearing aids
Hospice
OBS that is part of ambulatory surgery admission
Palliative care
Tissue plasminogen activator
Stress echocardiogram
Wound care - facility
ER to OBS
Health Plan Responsibility (both authorization and payment)
Self injectables
Out of Area Emergency (per OOA Grid)
Transplants
Transgender Services
Experimental/Investigational/Clinical Trials

AMBULATORY SERVICES REQUIRING PRIOR AUTHORIZATION:

Category	Description	Codes	Code Description
Ear, nose, throat (ENT) services	Balloon sinuplasty	31295 - 31298	Balloon sinuplasty
	polyp excision, choanal atresia rhinoplasty or septoplasty	30110	Excision, nasal polyp(s), simple.
		30115	Excision, nasal polyp(s), extensive.
		30540	Repair choanal atresia; intranasal.
		30545	Repair choanal atresia; transpalatine.
		30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft.
		31237	Under Endoscopy Procedures on the Accessory Sinuses
Joint surgeries	all	25350	Hand/Wrist: OSTEOTOMY RADIUS DISTAL THIRD
		25355	Hand/Wrist: OSTEOTOMY RADIUS MIDDLE/PROXIMAL THIRD
		25360	Hand/Wrist: OSTEOTOMY ULNA
		25365	Hand/Wrist: OSTEOTOMY RADIUS & ULNA
		25370	Hand/Wrist: MLT OSTEOTOMIES W/RELIGNMT IMED ROD RADIUS/ULNA
		25375	Hand/Wrist: MLT OSTEOTOMIES W/RELIGNMT IMED ROD RADIUS&ULNA
		25390	Hand/Wrist: OSTEOPLASTY RADIUS/ULNA SHORTENING
		25391	Hand/Wrist: OSTEOPLASTY RADIUS/ULNA LENGTHENING W/AUTOGRAFT
		25392	Hand/Wrist: OSTEOPLASTY RADIUS & ULNA SHORTENING
		25393	Hand/Wrist: OSTEOPLASTY RADIUS&ULNA LENGTHENING W/AUTOGRAF
		25394	Hand/Wrist: OSTEOPLASTY CARPAL BONE SHORTENING
		22010-22899	Spinal surgery, including decompression, fusion, and disc replacement
		27380-27499	Knee: Repair, Revision, and/or Reconstruction Procedures on the Femur (Thigh Region) and Knee Joint
		27599-27599	Knee: Other Procedures on the Femur or Knee Joint

		27097-27187	Hip: Repair, Revision, and/or Reconstruction Procedures on the Pelvis and Hip Joint
		27299-27299	Hip: Other Procedures on the Pelvis or Hip Joint
		24300-24498	Elbow: Repair, Revision, and/or Reconstruction Procedures on the Humerus (Upper Arm) and Elbow
		24999-24999	Elbow: Other Procedures on the Humerus or Elbow
		27650-27745	Ankle/Leg: Repair, Revision, and/or Reconstruction Procedures on the Leg (Tibia and Fibula) and Ankle Joint
		27892-27899	Ankle/Leg: Other Procedures on the Leg (Tibia and Fibula) and Ankle Joint
		23395-23500	Shoulder: Repair, Revision, and/or Reconstruction Procedures on the Shoulder
		23450-23466	Shoulder: Bankart/Rotator Cuff Repair (Open)
		23470-23473	Shoulder: Joint Replacement
		29800–29999	Arthroscopy
Neuro and spinal cord stimulators	all	63650	Implant neuroelectrodes
		63655	Implant neuroelectrodes
		63661	Remove spine eltrd perq aray
		63662	Remove spine eltrd plate
		63663	Revise spine eltrd perq aray
		63664	Revise spine eltrd plate
		63685	Ins/rplc spi npg/rcvr pocket
		63688	Rev/rmv imp sp npg/r dtch cn
		L8680	Implt neurostim elctr each
		61850-61892	Neurostimulators (Intracranial) Procedures on the Skull, Meninges, and Brain
		64553-64598	Neurostimulator Procedures on the Peripheral Nerves
		61885	Insertion/replacement of a neurostimulator pulse generator for a cranial device.
Orthognathic procedures	TMJ treatment	20999	Unlisted procedure, musculoskeletal system, head and neck
		41899	Unlisted procedure, excision of soft tissue of mouth
		97035	Ultrasound therapy

		D7980	TMJ arthroscopy
		29804	Surgical Arthroscopy
		21010	Arthrotomy
		21060	Meniscectomy/Discectomy
		21240	Disc Plication/Arthroplasty
		21050	Condylectomy
		21243	Total Joint Replacement
		21196	Mandibular Osteotomy (BSSO)
		21141–21147	Le Fort I Maxillary Osteotomy
		21198	Maxilla/Mandible Segments
		21121	Genioplasty
Spinal surgery	laminotomy, fusion, diskectomy, vertebroplasty, nucleoplasty, stabilization, and X-Stop	63001-63053	Posterior Extradural Laminotomy or Laminectomy for Exploration/ Decompression of Neural Elements or Excision of Herniated Intervertebral Disks
		+63035	Add on for each additional interspace treated during the same surgery.
		22612	Fusion: Lumbar Spine: Posterior/Posterolateral
		22630	Fusion: Lumbar Spine: Posterior Interbody Fusion (PLIF/TLIF)
		22558	Fusion: Lumbar Spine: Anterior Interbody Fusion (ALIF/XLIF/OLIF)
		22554	Fusion: Cervical Spine: Anterior Interbody Fusion (ACDF)
		22600	Fusion: Cervical Spine: Posterior Fusion
		22610	Fusion: Thoracic Spine: Posterior Fusion
		22556	Fusion: Thoracic Spine: Anterior Interbody Fusion
		+22585, +22614, +22632, +22634	Fusion: Used for each extra level fused.
		+22842, +22845, +22846	Fusion: Insertion of spinal instrumentation (screws, rods, plates).
		+20930, +20936, +20938	Fusion: Harvest or insertion of bone graft material.
		63075	Diskectomy: Cervical Spine: Anterior
		63077	Diskectomy: Thoracic Spine: Anterior/Anterolateral

		63055	Diskectomy: Thoracic Spine: Posterior (Transpedicular)
		62380	Diskectomy: Lumbar/Thoracic: Endoscopic
		22510	Vertebroplasty: Cervicothoracic (Neck & Upper/Mid Back)
		22511	Vertebroplasty: Lumbosacral (Lower Back & Sacrum)
		+22512	Vertebroplasty: Add-on code for each additional vertebral body treated during the same session. (Cervicothoracic or Lumbosacral)
		62287	Nucleoplasty: DCMPRN PX PERQ NUCLEUS PULPOSUS 1/MLT LVL LUMBAR
		22840	Stabilization: Posterior non-segmental instrumentation (e.g., Harrington rod technique, without fixation at each segment).
		+22842	Stabilization: Posterior segmental instrumentation, 3 to 6 vertebral segments.
		+22845	Stabilization: Anterior instrumentation; 2 to 3 vertebral segments.
		+22846	Stabilization: Anterior instrumentation; 4 to 7 vertebral segments.
		+22847	Stabilization: Anterior instrumentation; 8 or more vertebral segments.
		+22848	Stabilization: Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum.
		+22849	Stabilization: Posterior segmental instrumentation, 7 to 12 vertebral segments.
		+22850	Stabilization: Posterior segmental instrumentation, 13 or more vertebral segments.
		22853	Stabilization: Insertion of interbody biomechanical devices (like cages) with integral central attachments at a single lumbar interspace.
		22867	Stabilization: Insertion of an interlaminar/interspinous process

		22868 22867 +22868 22869 +22870	stabilization/distraction device with open decompression but without fusion at a single lumbar level, including imaging when performed. Stabilization: Insertion of an interlaminar/interspinous process stabilization/distraction device without open decompression or fusion at a single lumbar level, including imaging when performed. X-Stop: insertion with open decompression for single and additional lumbar levels, respectively. X-Stop: add-on code for the insertion of an interlaminar/interspinous process stabilization/distraction device without fusion X-Stop: used for insertion without open decompression or fusion for single and additional lumbar X-Stop: add-on code for the insertion of an interlaminar/interspinous process stabilization or distraction device at a second lumbar level
Uvulopalatopharyngoplasty (UPPP) and laser-assisted UPPP	all surgical in this category	42145 42299 HCPCS=S2080	Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty) Unlisted procedure, palate, uvula. Primary code recommended when a specific CPT code does not exist. Laser-assisted uvulopalatoplasty (LAUP). Temporary, non-Medicare national code (S-code) often accepted by commercial/private payers to specifically describe LAUP.
Vestibuloplasty	all surgical in this category	40830-40845 D7030	Repair Procedures on the Vestibule of Mouth Dental Procedure: Sialolithotomy is a surgical procedure for the removal of a sialolith

Cosmetic Codes:
Breast Augmentation: 19325 - Cosmetic unless DX is CA diagnosis and approved as Medically Necessary
Breast Lift: 19318 - Cosmetic

Breast Reduction: 19318 - Medically Necessary must have prior authorization not always considered cosmetic DX covered per Women's Health and Cancer rights acts of 1998, also include 19300 Mastectomy for gynecomastia- Is not cosmetic and covered for males with certain dx including non CA and non-tumor DX
Facelift: 15828 Cosmetic
Rhinoplasty: 30400 - Cosmetic unless DX is deviated septum
Blepharoplasty (Eyelid Surgery): 15820 - Cosmetic unless medically necessary additional possible codes 15821, 15822 & 15823 Brow Ptosis 67900 and Upper brow 67901, 67902, 67903, 67904, 67906, 67908, 67909, Lid Reduction 67911, Lagophthalmos 67911, 67912, Ectropion & Entropion 67914, 67915, 67916, 67917, 67821, 67922, 67923, 67924, Canthoplasty & Canthopexy 21280, 21282, 67950, 67961, 67966, Floppy Eyelid Syndrome 67961 & 67966
Abdominoplasty (Tummy Tuck) : 15847 - Is not always considered cosmetic, may be medically necessary along with the following codes 15830, 15877,15878, 15879, 15832, 15833, 15834, 15835 must have prior approval. The cosmetic procedures are 15836, 158837, 15838, 15839, 15876
Liposuction: 15876 - Is not always considered cosmetic, may be medically necessary if dx is lipedema possible other codes include 15877, 15878 & 15879
36438 - Is cosmetic treatment for spider veins - The non cosmetic procedures are 36465, 36466, 36470 & 36471 for sclerotherapy for up to 3 sessions per leg within a year. (includes the 0744T code to insert the port/valve)
Non- Surgical Procedures
Botox: 64612- Not always Cosmetic used to treat migraines, GI issues and Urological disorders this is multi-purpose
Dermal Filler: 11950-11954 Cosmetic
Chemical Peels: 17360 Cosmetic
Microdermabrasion: 15780 Cosmetic
Laser Skin Resurfacing: 17106-17108 Cosmetic - can be medically necessary if related to a burn victim
The following codes are considered Cosmetic; the codes do not improve a Functional, Physical, or Physiological impairment
11950 Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
11951 Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
11952 Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
11954 Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc
15775 Punch graft for hair transplant; 1 to 15 punch grafts
15776 Punch graft for hair transplant; more than 15 punch grafts
15780 Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781 Dermabrasion; segmental, face
15782 Dermabrasion; regional, other than face
15783 Dermabrasion; superficial, any site (e.g., tattoo removal) 15786 Abrasion; single lesion (e.g., keratosis, scar)
15787 Abrasion; each additional 4 lesion or less) List separately in addition to code for primary procedure) 157888 Chemical peel, facial; epidermal
15789 Chemical peel, facial; dermal

15792 Chemical Peel, nonfacial; epidermal
15793 Chemical peel, nonfacial; dermal
15824 Rhytidectomy; forehead
15825 Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826 Rhytidectomy; glabellar frown lines
15828 Rhytidectomy; cheek, chin, and neck
15829 Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
17380 Electrolysis epilation, each 30 minutes
21270 Malar augmentation, prosthetic material
69090 Ear piercing
69300 Otoplasty, protruding ear, with or without size reduction Cosmetic and Reconstructive Procedures
The following codes may be Cosmetic; review is required to determine if considered Cosmetic or Reconstructive
11920 Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921 Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
11922 Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
11960 Insertion of tissue expander(s) for other than breast, including subsequent expansion
14000 Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001 Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14020 Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less
14021 Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
14040 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet 10.1 sq cm to 30.0 sq cm
14060 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
14061 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm
14301 Adjacent tissue transfer or rearrangement, any area, defect 30/1 sq cm to 60.0 sq cm
14302 Adjacent tissue transfer or rearrangement, any area,; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
15570 Formation of direct or tubed pedicle, with or without transfer; trunk
15572 Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs
15574 Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
15730 Midface flap (i.e.., zygomaticofacial flap) with preservation of vascular pedicles(s)

15731 Forehead flap with preservation of vascular pedicle (e.g., axial pattern flap, paramedian forehead flap)
15733 Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (i.e., buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)
15734 Muscle, myocutaneous, or fasciocutaneous flap; trunk
15736 Muscle, myocutaneous, or fasciocutaneous flap; upper extremity
15738 Muscle, myocutaneous, or fasciocutaneous flap; lower extremity
15740 Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel
15756 Free muscle or myocutaneous flap with microvascular anastomosis
15769 Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)
15771 Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate. Note: Refer to the Health Plan Medical Policy titled Breast Reconstruction.
15772 Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure) Note: Refer to the Health Plan Medical Policy titled Breast Reconstruction.
15773 Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
15774 Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)
17999 Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19316 Mastopexy
19325 Breast augmentation with implant
21137 Reduction forehead; contouring only
21138 Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139 Reduction forehead; contouring and setback of anterior frontal sinus wall
21172 Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175 Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179 Reconstruction, entire or majority of forehead and/ or supraorbital rims; with grafts (allograft or prosthetic material)
21180 Reconstruction, entire or majority of forehead and/ or supraorbital rims; with autograft (includes obtaining grafts)
21181 Reconstruction by contouring of benign tumor of cranial bones (e.g., fibrous dysplasia), extracranial
21182 Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra-and extracranial excision of benign tumor of cranial bond (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm
21183 Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra-and extracranial excision of benign tumor of cranial bond (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 40 sq cm but less than 80 sq cm

21184 Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra-and extracranial excision of benign tumor of cranial bond (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 sq cm
21208 Osteoplasty, facial bones, augmentation (autograft, allograft, or prosthetic implant)
21209 Osteoplasty, facial bones; reduction
21230 Graft; rib cartilage, autogenous, to face, chin , nose or ear (includes obtaining graft)
21235 Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
21248 Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
21249 Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete
21255 Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
21256 Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (e.g., micro-ophthalmia)
21260 Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach
21261 Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach
21263 Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement
21267 Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
21268 Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach
21275 Secondary revision of orbitocraniofacial reconstruction
21295 Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); extraoral approach
21296 Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); intraoral approach
21299 Unlisted craniofacial and maxillofacial procedure
28344 Reconstruction, toe(s); polydactyly
30540 Repair choanal atresia; intranasal
30545 Repair choanal atresia; transpalatine
30620 Septal or other intranasal dermatoplasty (does not include obtaining graft)
L8600 Implantable breast prothesis, silicone or equal
L8607 Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping necessary supplies
Q2026 Injection, Radiesse, 0.1 ml
Q2028 Injection, sculptra, 0.5 mg
CODES FOR ADDITIONAL CATEGORIES LISTED ABOVE:
Intensity Modulated Radiation Therapy (IMRT)
Treatment Planning & Delivery:
77301 – IMRT planning (includes dose-volume histograms)
77338 – Multi-leaf collimator device(s) for IMRT (used with 77301)
Treatment Delivery:

77418 – IMRT delivery (non-proton, non-neutron)
G6015 – IMRT delivery (Medicare-specific HCPCS code, used interchangeably with 77418)
G6016 – Compensator-based IMRT delivery (if applicable, rarely used)
Neutron Beam Therapy
77422 – Neutron beam treatment delivery; single treatment session
77423 – Neutron beam treatment delivery; multiple treatment sessions
Proton Beam Therapy
Treatment Delivery:
77520 – Proton beam treatment; simple
77522 – Proton beam treatment; intermediate
77523 – Proton beam treatment; complex
77525 – Proton beam treatment; very complex
(The complexity depends on factors like number of fields, modulation, and beam shaping.)
Stereotactic Radiosurgery (SRS) & Stereotactic Body Radiotherapy (SBRT)
Intracranial Stereotactic Radiosurgery (SRS):
61796 – SRS, 1 lesion, using linear accelerator
61797 – Each additional lesion (add-on code)
61798 – SRS, 1 lesion, using mult-source Cobalt-60
61799 – Each additional lesion (add-on code)
61800 – Application of stereotactic headframe
Stereotactic Body Radiotherapy (SBRT) (typically extracranial):
77373 – SBRT treatment delivery, per fraction
77435 – SBRT management, per treatment course
SRS/SBRT Planning & Guidance (may be shared across modalities):
77295 – 3D radiotherapy plan (used in SBRT/SRS planning)
77371 – Radiation treatment delivery, stereotactic, complete course of treatment, 1 or more sessions
77372 – SRS delivery, linear accelerator-based, 1 session
77373 – SRS/SBRT delivery, per fraction (as above)

Health Net Contacts
Self-injectables – Centene Pharmacy Services phone number (800) 548-5524, option 3 https://pharmacy.envolvehealth.com Carrier ID: NVCHN
Out of Area Emergency (per OOA Grid) – • Call the phone number on the back of the members ID card
Transplants: • Phone number (866) 447-8773 option 2 • Fax number (833) 769-1142 • California_Transplant_Services_CTU@CENTENE.COM
Transgender Services: • Phone number (800) 641-7761 • Fax number (844) 694-9165 • PCU_Admin@HealthNet.com
Experimental/Investigational/Clinical Trials: • Call the phone number on the back of the members ID card

Reminder: This list pertains to those services that are typically Canopy Health's responsibility although that may differ depending on our DOFR with each IPA. Each IPA can apply additional prior auth requirements for services that are the IPA's responsibility.

Canopy Health Medical Groups/IPAs conduct the following types of review per their respective policies and procedures, and in coordination with the member's health benefit plan, including but not limited to:

- Prospective Review
- Medically Urgent Services Review
- Concurrent Review of patients admitted to acute care hospitals, rehab facilities and skilled nursing facilities
- Discharge Planning
- Retrospective review (commercial patients only)
- Ancillary Services Management

UM Contacts

Dignity Health Medical Network - Santa Cruz
(831) 465-7800

Hill Physicians Medical Group
(800) 445-5747

John Muir Physician Network
(925) 952-2887

Providence Medical Network
(800) 627-8106 / for referrals UM Ambassadors Team (714) 449-4923

SCCIPA
(800) 977-7332

Non-Emergency Ambulance Transportation

Effective March 1, 2023, Canopy Health requires medical necessity review and prior authorization for all non-emergency ambulance transportation. Medical necessity review and prior authorization does not apply to 911 and Emergency Medical System calls, interfacility transfers to a higher level of care and repatriation via ambulance. All prior authorization requests for non-emergency ambulance transportation are classified Urgent Concurrent Review which requires a 24-hour turnaround time consistent with the Department of Managed Health Care Timeliness Standards.

Prior Authorization – Self-Injectable Medication

Effective January 1, 2022, the authorization and coordination of self-injectable drugs is the responsibility of our health plan partners' Pharmacy Benefit Management (PBM) vendors.

- Health Net: For CanopyCare, and Blue and Gold members, please contact Centene Pharmacy Services (800-548-5524, option 3).
- United Healthcare: SVA , please contact OptumRx (800-356-3477).

Emergent Self-Injectable Prescriptions for Commercial Members

For self-injectable medications needed emergently, such as triptans, epinephrine, and enoxaparin, physicians may send prescriptions to retail pharmacies, which may dispense up to seven days' supply without prior authorization. If more than seven days of medication is required after dispensing by the retail pharmacy, the physician must also submit the prior authorization form 61-211 and prescription to the Member's health plan PBM vendor as noted above.

Turnaround times for Self-Injectable Authorizations and Contact Numbers

Type of Request	Decision Timeframe	Practitioner and Member Notification Timeframe
Prescription Drugs CA Health & Safety Code section 1367.241 (CA SB 282; 2015-2016) **Exigent circumstances" exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function **OR** when an insured is undergoing a current course of treatment using a non-formulary drug.*	▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request	Practitioner Approval or Denial: ▪ **Non-urgent:** Within 24 hours of the decision, not to exceed 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request Member Approval of Denial ▪ **Non-urgent:** Within 2 business days of the decision ▪ **Urgent request or exigent circumstances*:** Within 72 hours of receipt of the request

Continuity of Care Requests

If a new Canopy Health member submits a request asking to continue to obtain services from a physician or a facility who is not in Canopy Health's network, with Continuity of Care rationale, to one of our IPAs/Medical Groups, the IPA/Medical Group should advise the member to submit their request directly to the parent health plan (UHC or Health Net) [Canopy Health Policy QM-001]. The links to UHC and Health Net's CoC request forms are below:

Continuity of Care | UnitedHealthcare

Continuity of Care Instructions - healthnet.com

CoC, when approved by the health plan, is unique rationale to approve an out of network (OON) request for a limited period. Typically, the member will receive a letter detailing the specific services and the time approved. If there is no CoC approval by the health plan, the IPA/Medical Group's UM team should confirm that the clinically necessary service is available (i.e., in-network provider is capable, available timely, within reasonable distance) before denying OON request as service being available in network.

Denial Notification

Verbal and written notice of denials and communications must meet health plan requirements. [Requirements are detailed in Canopy Health Policies UM-001, UM-005 and UM-008].

Emergencies

Emergency services are covered both in-network and out-of-network and do not require prior authorization.

Notification of Admission

All elective acute care hospital and skilled nursing facility ("SNF") admissions require authorization from the member's assigned IPA/Medical Group's Utilization Management Department. Timeframes for notification are determined by the policies and procedures of each participating IPA/Medical Group. Notification of emergency admissions should be made to the patient's Medical Groups/IPAs within 24 hours or the next business day of presentation.

Quality Management

Canopy Health collaborates with its contracted physicians, facilities and health plans to validate adherence to quality standards established by federal, state and local agencies and accreditation entities. Canopy Health establishes annual goals with our hospital and medical group partners across its alliance to optimize patient care and appropriateness of care for its members.

The Quality Management ("QM") Program for Canopy Health is designed to improve the quality of health care provided to Canopy Health plan members. To the extent applicable, the QM Program facilitates members' behavioral health services from their contracted health plan. [Canopy Health Policy QM-008]

The goals of Canopy Health's QM Program are to:

- Improve the safety and quality of care and service to all members by:
  - overseeing that the quality and continuity of care meet professionally recognized standards of practice and are delivered to all members, and
  - identifying, evaluating and working with Canopy Health providers to correct quality of care problems within all partner organizations;
- Optimize satisfaction of members and practitioners/providers by assessing, pursuing and monitoring opportunities for improvement; [Canopy Health Policy UM-007]
- Validate optimized service delivery, including care accessibility, availability, and utilization of services, to meet professionally recognized standards of practice;
- Foster a multi-disciplinary and collaborative approach to quality improvement involving all Canopy Health partnering medical groups, IPAs, hospitals, other providers, and health plans whose services directly affect members' health care quality, service, access, and safety;
- Review and update existing quality related policies and procedures, validate compliance with all external requirements and standards and create new policies and procedures as needed;
- Maintain systems to collect, synthesize, and report data about quality and service reliably and in a timely fashion from various sources. Sound study designs and statistical techniques are applied when monitoring and developing reports to validate that appropriate follow-up actions may be taken; [Canopy Health Policy UM-002]
- Monitor procedures ensuring that members do not experience discrimination based on race, ethnicity, color, national origin, ancestry, religion, sex, age, mental or physical disability, marital and domestic partner status, gender, gender expression, gender identity, genetic information, sexual orientation or source of payment in the delivery of health care services; and
- Validate the identification, evaluation and planning for individual members is done consistently across all Medical Groups/IPAs wherever this function is delegated to Canopy Health by the health plan.

A complete list of all quality management policies and procedures are provided on our website https://www.canopyhealth.com/en/providers/policies-procedures.html .

Care Coordination Program

Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes (NCQA, 2013). MCG Guidelines ®, AHRQ and NCQA standards are utilized to identify case types, establish clinical assessment criteria and supportive services for care planning. [Canopy Health Policy QM-001]

Care coordination efforts and services include consideration of the member's health plan benefits, diagnoses, co-morbidities, psychosocial needs and community program access. The medical groups/IPAs notify and collaborate with PCP's, treating specialists and health plans to coordinate care for members. The goals of Canopy Health's care coordination efforts are to help patients and their families and others in their support network to manage medical conditions and related psychosocial problems more effectively, optimize the member's functional health status, coordinate care across various providers and care settings, eliminate duplication of services, and avoid duplicative and excessive medical services. [Canopy Health Policy QM-012]

The Transitions of Care Program is a care management collaboration between our medical groups and hospitals' case managers and Canopy Health's clinical staff. Nurses and care coordinators work together every day to ensure our members are getting all of the medically necessary care, at the appropriate level of service, in the right hospital to meet their needs. When it is time for that member to be discharged either to their home, or to a skilled nursing facility or even transferred to another hospital, the transitions of care team ensures a safe and seamless transfer to the individual's next site of care.

Care Managers and coordinators can be accessed during normal business hours. The Medical Groups/IPAs must maintain and coordinate care records among providers to assure access and in accordance with HIPAA and professional standards. Members and/or caregivers communicate with Care Managers through various means (telephone and secure messaging when available). PCPs are notified in writing about a member who meets criteria for and enrollment in care coordination. All patients are informed of their right to refuse care coordination services. Services offered as part of the program include but are not limited to:

- Education about the condition (s)
- Medication reconciliation and self-care-training
- Assistance with arranging doctor visits/appointments
- Help with referrals to different care providers or services
- Assistance with identifying community support or services available to meet individual needs e.g. In Home Support Services (IHHS), nutrition services, assistance with utilities, safety repairs, other community support programs
- Help with physician access and involvement in developing a treatment plan
- Assist members in communicating with their health care providers

- Advanced illness management and life planning discussion when needed

Complex Case Management Program

Purpose

Complex Case Management (CCM) is a collaborative process of assessing, planning, facilitating, coordinating care, monitoring, evaluating and advocating. Case managers are responsible for the initial and ongoing assessments of members in the CCM Program. The process may include the member and his/her family, caregivers, community resources, treating physicians, hospital staff and ancillary service providers. CCM may extend over a period of several weeks or months based on the individual's condition, care plan and personal goals. A multidisciplinary care team approach is often required for individuals enrolled in CCM. CCM includes members of all ages.

In contrast to CCM, routine Case Management services are primarily focused on specific episodes of care, to help an individual and/or family or caregivers obtain care and services. Routine case management is focused and short-term, typically accomplished in 30 days or fewer, and includes the following:

- transitions of care from one setting to another (e.g., hospital to home, SNF to home)
- referral to parent Health Plan disease management programs
- referral to delegates wellness and health education programs and classes

The criteria used to identify members for CCM include but are not limited to NCQA, MGC, Epic Care Management Module, Healthy Planet, LACE, Cozeva, Ascender and MedPOINT Management (MPM) high dollar claims reports.

The CCM Program provides coordination of medical care, covered benefits and community services to members who have experienced a serious event or illness or have complex medical and/or psychosocial needs or care gaps that require significant resources or need support and advocacy to navigate the health care system successfully and receive care.

Goals of the CCM Program include proactive identification of at-risk members, support of members and their families, personalized care planning and attainment of goals, effective and efficient use of resources, and excellent customer service for members and their families, physicians and community partners.

Scope

Canopy Health delegates CCM to member IPA/Medical Group CCM departments where such delegation has been approved by the parent health plan. When not delegated, the health plan retains responsibility for case management.

Case Management Responsibility for IPA/Medical Groups by Health Plan and Product		
IPA/Medical Group	**Health Net Blue and Gold CanopyCare**	**UHC SVA**
Hill Physicians Medical Group	Delegated	Delegated
John Muir Physician Network	Delegated	Delegated
Providence Medical Network (CanopyCare and SV Harmony only)	Delegated	Delegated
Santa Clara County IPA	Not delegated	Delegated
Dignity Health Medical Network – Santa Cruz	Not delegated	Delegated

Health Net retains Complex Case Management for members through their CCM RN and LCSW staff. To refer a Health Net SCCIPA or Dignity Health member for CCM please contact:

Kristine Douglas, MPH, LCSW
Clinical Program Manager

Health Net, Inc.
101 N. Brand Blvd, Suite 1500, CA 91203
Phone: (818) 594-6210 Fax: (866) 667-8099
www.healthnet.com

Population Assessment

The characteristics and needs of the adult (ages 18 and older) are evaluated annually by the IPA/Medical Group responsible for Case Management. The CCM Program is refined and revised based on the assessment results.

Eligibility for Case Management

The CCM Program is available to all members at no cost. All members have the right to consent or refuse CCM services. Eligibility begins the day the member is identified and referred by any means. An initial assessment or documentation of outreach and/or refusal is completed in no later than 30 days.

Referral Sources

Members can be referred to the CCM Program by a variety of means. Each medical group uses a unique set of data sources and staff. These include but are not limited to all the following:

- Complexity alerts – multiple providers, high number of prescriptions, multiple care gap alerts
- Health Plan Programs
- Health Risk Assessment forms
- High resource use
- Inpatient – care transitions team members, case managers, discharge planners, hospitalists, SNF specialists
- Other IPA/Medical Group programs
- Risk Stratification Systems – DxCG, LACE, LOA algorithm (Likelihood of Admission), HCC, Hopkins RSS
- Self or family referrals
- Treating physician or mid-level provider
- Utilization Management staff – case managers, medical directors, concurrent review, patient care coordinators, UN RN's

Initial Assessment

Case managers conduct an initial assessment within 30 days of referral. Initial assessments are conducted face-to-face or by telephone call based on individual's need and the responsible CCM entity's protocols. All contacts and attempted contacts by case managers to members are documented using a system that has automatic user signature, the member's ID and a time/date stamp and a prompt for follow up based on the individual care plan when established.

Delegated medical groups submit a CCM monthly log of all Canopy Health members active in CCM. Canopy Health reviews these logs monthly to ensure timely initial assessment and communication. CCM logs include: patient name, DOB, health plan ID, health plan name, medical group, primary diagnosis, CCM referral date, case open date, if not opened/date,

reason case in not opened, date MD informed that case was not opened, means of informing MD, date CCM closed, discharge status.

The outreach process and documentation requirements vary based on the responsible CCM entity but at a minimum include a series of phone calls and documentation of the member's consent/refusal or unable to reach status. The minimum components of the initial assessment include all the following.

- clear documentation of the member's eligibility for CCM.
- eligibility and enrollment dates
- consent to participation
- self-reported health status, including condition, and comorbid conditions and specific concerns, including the date of the onset and status (e.g., stable vs. instable)
- clinical history including significant past medical conditions and surgeries, medications including dose/times/prescriber, the member's understanding of the medications and medication allergies.
- activities of daily living, functional status and health literacy
- behavioral health status including cognitive function, impairments, substance use and psychiatric conditions
- psychosocial health including beliefs systems, cultural and linguistic considerations, preferences, and limitations
- evaluation of any perceived barriers to meeting treatment goals, including lack of caregiver support, access to care, transportation, and financial constraints
- evaluation of visual and hearing needs, preferences and limitations
- evaluation of caregivers and their knowledge base and ability to impact care
- evaluation of available resources from family, community, community programs and medical benefits and health system sources
- assessment of life-planning activities such as POLST and advance directives

Continuing Care Management Process

Care management documentation meets NCQA and the standards developed by each responsible entity. Delegated and contracted entities are responsible for ongoing monitoring of documentation. Canopy Health collects and reviews quarterly CCM patient rosters from each delegated and contracted entity. Elements of the roster include member name, reason for referral, referral date, open and close dates, process status (goals met/not met/in progress) and outcome status (discharged/deceased/declined/unable to participate in care plan goal attainment). Care managers do the following:

- develop an individualized care plan, including prioritized short and long-term goals that respect the member's and the caregiver's personal goals, preferences and engagement in the CCM program
- work with all members of the care team to facilitate effective care and resource use
- coordinate care and services, and refer the member and caregivers to disease management programs, wellness programs, community resources, social services,

behavioral health care providers or palliative care as appropriate, based on the individuals care plan
- identify and address barriers to meeting goals
- identify self-care strategies for adherence to care planning and goal attainment
- identify red flags in self-care
- provide education materials that are appropriate for the member's level of health literacy
- develop a follow up and communication plan based on the member's level of intensity and acuity
- coordinate care among treating physicians and other providers
- coordinate transitions of care, facility transfers
- coordinate transitions resulting from loss of health care benefits
- coordinate care as members transition out of the CCM program,

Discharge from the CCM Program

A member remains in the CCM Program until the following occur: all self-care goals are met, treatment for the trigger condition (medical, pharmacy, psychosocial or behavioral health) has concluded, or the member declines to continue participation or is no longer eligible with Canopy Health.

CCM Program Evaluation

Canopy Health annually audits the medical groups to ensure that these delegates follow their documented processes, NCQA standards and regulatory requirements for ongoing management of members receiving CCM services.

Access to Care

The California Department of Managed Health Care requires Knox-Keene licensed entities to adhere to the following standards for timely access to care. All Canopy Health participating providers must meet these standards for appointment and telephone wait times. [Canopy Health Policy UM/AA-001]

DMHC Regulated Appointment Wait Times

Canopy Health members have the right to appointments within the following time frames:

Type of Appointment	Wait time
Urgent	
• for services that do not require prior approval	48 hours
• for services that require prior approval	96 hours
Non-Urgent	
• Primary care	10 business days
• Specialist	15 business days
• Behavioral Health care provider (non-physician)	10 business days
• Other services to diagnose or treat a health condition	15 business days
• Behavioral Health follow up care (non-physician)	10 business days from prior appointment

DMHC Regulated Telephone Wait Times

- Canopy Health members may call 24 hours a day, 7 days a week. If the member must wait for a professional to call back, that call must occur within 30 minutes.
- During normal business hours, the phone must be answered within ten minutes.

Exceptions to Timely Access Requirements

- The purpose of the timely access law is to make sure members receive the care they need. Sometimes members need appointments even sooner than the law requires. In this case, members and PCPs can request that the appointment be sooner.
- Providers may give members a longer wait time if it would not be harmful to their health. It must be noted in the medical record why a longer wait time is necessary and that it will not be harmful to the member's health.
- If a member cannot get a timely appointment in the service area because there are not enough Alliance providers, Canopy Health and the member's medical group must help the member to get an appointment with an appropriate provider out of network.

DMHC Regulated After-Hours Access

Canopy Health, through its participating providers, contracted health plans and internal processes provides 24 hours a day, 7 days per week telephone triage for immediate clinical support of everyday health issues and questions. The triage or screening waiting time does not exceed 30 minutes. Registered nurses may respond to calls and may: provide protocol-based advice for minor injuries and illnesses, identify emergency health situations, explain medications, and prepare patients for doctor visits.

Health Plans contracting with Canopy Health offer routine, urgent, and emergency behavioral health services through their contracted behavioral health network, including inpatient and outpatient care. These services include crisis intervention and stabilization as well as psychiatric inpatient hospital services within the service area, 24 hours a day, 7 days a week.

General Administrative Requirements

Provider Responsibilities

Participating providers are responsible for:

- providing health care services within the scope of the provider's practice and qualifications, that are consistent with generally accepted standards of practice;
- accepting Canopy Health members as patients on the same basis that the provider accepts other patients (nondiscrimination);
- following the Canopy Health Referral Policy and providing timely communication and feedback regarding member healthcare needs to affiliated physicians;
- obtaining current insurance information from the member;
- adhering to standards of care and Canopy Health policies to perform utilization management and quality improvement activities, including prior authorization of necessary services and referrals; [Canopy Health Policy QM-008]
- informing the member that services may not be covered when referring to physicians outside the network unless prior authorization has been issued;
- cooperating with Canopy Health and its participating providers to provide or arrange for continuity of care to members according to state regulations undergoing an active course of treatment in the event of provider termination;
- operating and providing contracted services in compliance with all applicable local, state and federal laws, rules, regulations, and institutional and professional standards of care, including federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), the anti-kickback statute (section 1128B(b)) of the Social Security Act), and Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rules at 45 CFR parts 160, 162 and 164. [Canopy Health Policy COM-001]

Provider Rights to Advocate on Behalf of the Member

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

- the member's health status, medical care or treatment options, including any alternative treatment that may be self-administered
- any information the member needs to decide among all relevant treatment options
- the risks, benefits and consequences of treatment or non-treatment

- the member's right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment and to express preferences about future treatment decisions

Nondiscrimination

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

Credentialing and Re-credentialing

Credentialing and re-credentialing of physicians and licensed individual practitioners is delegated to Canopy Health's partner IPAs/Medical Groups. Canopy Health's Medical Director chairs the Canopy Health Credentialing Committee which oversees these activities conducted by each IPA/Medical Group's credentialing committee.

Canopy Health credentials participating ancillary facilities through MedPOINT Management (MPM). Ancillary facilities are credentialed per the state and federal regulations; such documentation and verification are provided to the Canopy Health Credentialing Committee.

Provider Policies and Procedures

Provider policies and procedures are available on Canopy Health's website at the following link https://www.canopyhealth.com/en/providers/policies-procedures.html

Appendix - Exhibits

1. Quick Reference Guide-Facility and Ancillary Claims Submission
2. Canopy Health contact list
3. Prescription Drug Prior Authorization Request Form
   AKA “Form 61-211”
4. Health Net CAR-T authorization flow chart
5. Canopy Health and Medical Group Case Management Contact List
6. Grievance and Appeals Forms:
   - Health Net
   - UnitedHealthcare Commercial

Claims Submission - Quick Reference Guide

This section of the Provider Manual provides a quick reference guide for provider offices to use when submitting facility and ancillary services claims to Canopy Health.

Checking Member Eligibility

Providers are responsible for verifying a member's eligibility prior to providing non-emergent medical services. Providers may verify member eligibility by accessing the member's Health Plan website or calling the Health Plan contact center. Canopy Health works with Health Net and UnitedHealthcare. See the member's Health Plan ID card for this information.

Filing a Claim

Providers are encouraged to file claims electronically whenever possible. Submitted claims should provide all required information; those claims submitted with missing data may result in a delay in processing or denial.

All Canopy Health facility and non-diagnostic ancillary service claims are processed by MedPOINT Management (MPM). Professional claims will continue to be processed by the participating Medical Groups and/or their respective vendors.

Where to Submit a Canopy Health Claim?

Paper claims can be mailed to: Canopy Health P.O. Box 7020-26 Tarzana, CA 91357

Provider Claims Disputes: Canopy Health P.O. Box 7020-26 Tarzana, CA 91357

Claims Department phone number: 800-898-1016

All other Provider inquiries: 800-898-1016

Electronic Claims Submission

Clearinghouse Name	Payer ID
Office Ally	MPM71
Change Healthcare	CNPY1

Website Information

- MedPOINT Management (MPM)
- **https://portal.medpointmanagement.com/sign-in**
    - This portal provides access to query and view status on facility claims, eligibility status, contracted providers, and other important information. Call Provider Services at 800-898-1016 for assistance.
- Canopy Health website – www.canopyhealth.com
    - This portal provides general information about Canopy Health as well as a searchable Physician and Hospital directory. There is a "Provider" section of the website that provides additional information for Providers about Canopy Health.
- General Questions
    - Canopy Health Provider Services: 800-898-1016
    - Health Net: 800-641-7761
    - United HealthCare: 877-842-3210

Canopy Health Contacts

Department	Contact Name	Email Address	Phone Number
Alliance Referral Program		CHalliancereferrals@CanopyHealth.com	
Claims	Michelle Capellino	michelle.capellino@canopyhealth.com	[510] 256-7473
Compliance	Lauren Sasaki	lauren.sasaki@canopyhealth.com	[415] 966-0879
Data Transfers	Michael Bandrowski	michael.bandrowski@canopyhealth.com	[415] 813-5572
Provider Relations, Contract Inquiries, Ancillary Credentialing	Summer Rosales Belinda Wong	Summer.rosales@canopyhealth.com belinda.wong@canopyhealth.com	[415] 966-2091 [510] 256-7476

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name: _____

Plan/Medical Group Phone#: (___) _____

Plan/Medical Group Fax#: (___) _____

Non-Urgent ___ **Exigent Circumstances** ___

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request. **Information contained in this form is Protected Health Information under HIPAA.**

Patient Information

First Name: _____ Last Name: _____ MI: ____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth:_____Male _ Female _ HT:___ WT:___ Allergies: __

Patient's Authorized Representative (if applicable): _____

Authorized Representative Phone Number: _____

Insurance Information

Primary Insurance Name:_____Patient ID Number: _____

Secondary Insurance Name:_____Patient ID Number: _____

Prescriber Information

First Name:_____Last Name:_____Specialty:_____

Address:_____City:_____State:___ Zip Code: _____

Requester (if different than prescriber): _____

Office Contact Person:_____NPI Number (individual): _____

Phone Number:_____DEA Number (is required): _____

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Fax Number (in HIPPA complaint area):_____Email: _____

Medication / Medical and Dispensing Information

Medication Name: _____

New Therapy: ___ Renewal: ___ Step Therapy Exception Request: ___

If Renewal: Date Therapy Initiated: _____

Duration of Therapy (specific dates): _____

How did the patient receive the medication?

Paid under Insurance Name: _____

Prior Authorization Number (if known):_____Other (explain): _____

Dose/Strength:_____Frequency:_____Length of Therapy/#Refills: _____

Quantity:_____Therapy/# Refills: _____

Administration:

Oral/SL:___Topical:__ Injection:____IV:___Other: _____

Administration Location:

Physician's Office: ___ Ambulatory Infusion Center:____ Patient's Home: ___

Home Care Agency: ___ Outpatient Hospital Care: ___ Long Term Care: ___

Other (explain): _____

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Patient Name:_____ID# _____

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step therapy exception request.

1. **Has the patient tried any other medication for this condition?**

   Yes (if yes, complete below):____ No: ____

Medications/Therapy (specify Drug Name and Dosage): _____

_____

Duration of Therapy (Specify Dates): _____

Response/Reason for Failure/Allergy: _____

2. **List Diagnoses:**

   _____

   ICD-10:

   _____

3. Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

   Attachments ___

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____

Date: _____

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

Plan/Insurer Use Only: Date/Time Request Received by

Plan/Insurer:_____Date/Time of Decision _____

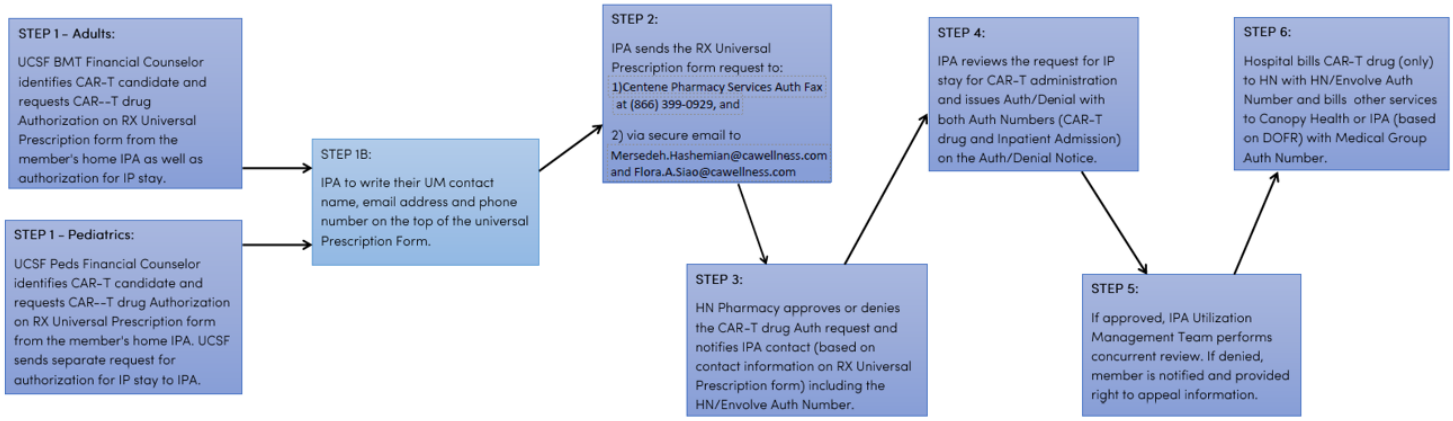
Fax Number: _____

Approved:_____ Denied:____Comments/Information Requested: _____

Health Net – Canopy Health CAR-T Authorization

This process is specific to Canopy Health for SmartCare and CanopyCare products and starting January 1, 2023 will also apply to Blue and Gold members (through Canopy Health).

**For Blue & Gold members, authorizations should be sent to the member's home IPA through December 31, 2022. Effective January 1, 2023 please follow the workflow below.*



Effective 1/1/2023 CAR-T for Blue & Gold will be Health Net's responsibility

For questions about this process, please contact Summer Rosales *at 415-966-2091 or Summer.Rosales@CanopyHealth.com*

Last review date: 10/04/2022

Canopy Health & Medical Group Contacts – Case Management

Organization	Phone	Email or Fax
Canopy Health	Email for questions or concerns	Clinicaloperations@canopyhealth.com
Dignity Health Medical Network – Santa Cruz	Case Management: 661-716-7100 ext: 6274	CCReferrals@Dignityhealth.org
Hill Physicians Medical Group	Case Management: 855-726-4764	Fax - 877-710-3330
John Muir Health	Case Management: 925-947-3300	AmbulatoryCM@johnmuirhealth.com
Providence Medical Network	CM Team line: 714-578-8682	CAREConnect@stjoe.org Fax – 949-372-3561
Santa Clara County IPA (SCCIPA)	Case Management: 800-977-7332	Fax 650-358-3131

Canopy Health & Medical Group Contacts – Utilization Management

Organization	Phone	Email or Fax
Canopy Health	Email for questions or concerns	Clinicaloperations@canopyhealth.com
Dignity Health Medical Network – Santa Cruz	Authorizations: 831-465-7800	Authorizations Fax: 831-464-7044
Hill Physicians Medical Group	Authorizations: 800-445-5747	Authorizations Fax: 844-449-3492
John Muir Health	Authorizations: 925-952-2887	Authorizations Fax#: 925-952-2865
Providence Medical Network	Authorizations: 714-449-4923 (UM Ambassador)	Authorizations Fax: 714-935-1431
Santa Clara County IPA (SCCIPA)	Auths to medical management fax line	Fax # 650-358-3131

Health Net of California, Inc

Confidential - Protected Health Information

HEALTH NET MEMBER GRIEVANCE FORM

Name: Date: Subscriber Identification Number: Group Number: Address:

Daytime Telephone No. Participating Physician Group:

Please explain in detail the circumstances that led to your dissatisfaction with Health Net of California, Inc. (Health Net). It is essential that you list the dates, persons and facilities involved, as completely as possible. Please include the original copy of any claims or bills received which are related to your issue. (Be sure to make a copy for your records.) Use reverse side or additional paper if necessary. Mail this form and documents to: Health Net, Appeals and Grievances Department, P.O. Box 10348, Van Nuys, CA 91410- 0348 or fax to (877) 831-6019.

Problem Statement: Date of Occurrence: Location: Provider Name:
Describe the problem/complaint in detail:

Use back of this form if additional space is needed.

Health Net's desire is to provide high quality medical care in the most satisfactory manner possible. To do this, we must be aware of any service difficulties you experience. By filling out this form, you are providing us with necessary information to continually maintain our high standards. We will respond to you in no later than 30 days. If you believe a delay in the decision making may impose an imminent and serious threat to your health, please contact our customer service department at 1-800-522-0088 to request an expedited review.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against t your health plan, you should first telephone your health plan at **1-800-522-0088** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be
available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO- 2219) and a TDD line (1-877-688-9891)** for the hearing and speech
impaired. The department's Internet Web site
http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

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CALIFORNIA

UnitedHealthcare

Grievance Form for Managed Care Members

Attention Medicare Advantage members – do not complete this form.

You have the right to file a formal grievance about any of your medical care or services. If you want to file, please use this form. *You may submit an appeal for a denial of a service or denied claims within 180 calendar days of your receipt of an initial determination through our Appeals Department.* There is a process you need to follow to file a grievance. UnitedHealthcare, by law, must give you an answer within 30 days. If you have any questions, or prefer to file this grievance orally, please feel free to call UnitedHealthcare Customer Service at 1-800-624-8822 or 1-800-422-8833 (TDHI), Monday through Friday, 7 a.m. to 9 p.m. If you think that waiting for an answer from UnitedHealthcare will hurt your health, call and ask for an 'Expedited Review.'

CURRENT PERSONAL INFORMATION (please print or type)				
Enrollment or Member ID #	Employer or Group Name			
Last Name	First Name		MI	Date of Birth
Address	Apt #	City	State	ZIP
Home Telephone ( )	Work Telephone ( )		Extension	

If someone other than the member is filing this grievance, please provide the following information:				
Name	Daytime Telephone ( )			
Relationship to Member				
Address	Apt #	City	State	ZIP

Due to privacy laws, you will be required to submit authorization of representation indicating you can file a complaint on behalf of the member.

DESCRIBE YOUR GRIEVANCE

Please describe your complaint. Be sure to include specific dates, times, people's and providers' names, places, etc. that were involved. Please send copies of anything that may help us understand your grievance to the address listed below or fax the documents to 1-866-704-3420.

☐ If you attach other pages, please check this box.

NOTICE TO THE MEMBER OR YOUR REPRESENTATIVE

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-624-8822** or **1-800-442-8833 (TDHI)** and use your health plan's grievance process before calling the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of the medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a **TDD (1-877-688-9891)** for the hearing- and speech-impaired. The department's Internet Web site **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

If you are a Federal Employee, you have grievance rights through the Office of Personnel Management (OPM) instead of the DMHC. Please reference your Federal Employees Health Benefits (FEHB) Program brochure, which states that you may ask OPM to review the denial after you ask UnitedHealthcare to reconsider the initial denial or refusal. OPM will determine if UnitedHealthcare correctly applied the terms of our contract when we denied your claim or request for service. Send your request for review to: Office of Personnel Management, Office of Insurance Programs Contracts Division 3, 1900 E Street NW, Washington, DC 20415-3630.

SIGNATURE	
Your Signature	Date
Signature of Representative	Date

Please sign and MAIL or FAX to:

ATTN: Appeals and Grievances Department
M.S. CA124-0160
P.O. Box 6107
Cypress, CA 90630-9972
FAX: 1-866-704-3420

IPA/Medical Group
Paper and Electronic Claims Submission Addresses

Hill Physicians Medical Group – Office Ally Payer ID: HILL01 P.O. Box 21913 Eagan, MN 55121
John Muir Physician Network – Office Ally Payer ID: JMH01 P.O. Box 31255 Salt Lake City, UT 84131
Meritage Medical Network – Bay Area Office Ally Payer ID: IP097 PO Box 2160 Oakland, CA 94621
SCCIPA – Office Ally Payer ID: 10378 P.O. Box 5680 San Mateo, CA 94402-5860
Dignity Health Medical Network-Santa Cruz – Office Ally Payer ID: DHM01 P.O. Box 5127 Oxnard, CA 93031
Providence Medical Network – Office Ally Payer ID: STJOE P.O. Box 10 Anaheim, CA 92815-0010

Revision History:

Version Date	Edited By	Reason for Change
4/1/17	M. Stevens	Creation date
1/5/18	M. Durbin	Updated to include new PBM vendor
1/18/18	A. Kmetz	Updated care coordination and management areas
1/19/18	M. Stevens	Updated with changes from health plan partners
1/22/18	M. Durbin	Added PDR appeal to DMHC information, added exhibits for 61-211 and Grievance & Appeals forms
2/1/18	M. Durbin	Removed paragraph about the WHA advantage referral program
7/1/18	M. Cruz	Added Santa Clara County IPA to the list of Canopy Health IPA/Medical Groups
7/1/18	M. Cruz	Added SCCIPA to the IPA Grid
7/1/18	M. Cruz	Added Good Samaritan Health Systems hospitals for Santa Clara County.
7/1/18	M. Cruz	Updated Claims Clearinghouse info. (Emdeon & Caparo are now a part of Change Healthcare)
10/1/18	R. Munson	Reformatted content into appropriate sections and made significant formatting updates. Added "Facility Claims – Quick Reference Guide." Added section on APR-DRG grouper.
1/1/20	C. Welsh	Annual update (Added MA, deleted WHA added Santa Cruz)
5/21/20	R. Scott	Compliance update.
1/1/2021	C. Welsh	Annual update, Added Marin and Santa Cruz Counties to MA, Added CanopyCare and Doctors Plan EPO
10/01/2021	C. Welsh	Added Harmony, Added Chinese Hospital and other minor changes.
1/1/2022	C. Welsh	Updated self-injectable section and health plan ID cards
5/1/2022	C. Welsh	Added Seton Medical Center and Seton Coastside
6/1/2022	C. Welsh	Added Providence Hospitals
12/1/2022	C. Welsh	Added Providence Medical Network, Sonoma and Napa Counties and St. Rose Hospital
6/1/2023	C. Welsh	Compliance Update (Language Assistance, Timely Access Standards), Added Continuity of Care section
11/1/2023	C. Welsh	Updated links for Doctors Plan EPO prior authorization process, Member Grievances and Appeals, updated Canopy Health Contacts and other minor changes.
1/1/2024	C. Welsh	Annual update, removed Health Net Smartcare CalPERS, health plan grid updated
6/1/2024	C. Welsh	Update to Canopy Health contact list and OOA admission language
10/1/2024	C. Welsh	Removed Meritage Medical Network
1/1/2025	C. Welsh	Annual update, removed Medicare Advantage and Doctors Plan EPO
7/1/2025	C. Welsh	Removed MDX from Electronic Claims Submissions
1/1/2026	C. Welsh	Annual update and updated with new MSO