

Key Aspects of HealthNet Settlement

In addition to the monetary component of the settlement, physicians and HealthNet have agreed to new levels of transparency and communication as well as a renewed commitment concerning business practices through a number of initiatives. In the agreement, Health Net has agreed to, among other things:

- A definition of medical necessity that ensures that patients are entitled to receive medically necessary care as determined by a physician exercising clinically prudent judgment in accordance with generally accepted standards of medical practice;
- Use of clinical guidelines that are based on credible scientific evidence published in peer reviewed medical literature (taking into account Physician Specialty Society recommendations, the views of Physicians practicing in the relevant clinical areas, and other relevant factors) when making medical necessity determinations;
- Provide physicians with access to an independent medical necessity external review process;
- Establish an independent external review board for resolving disputes with physicians concerning many common billing disputes;
- Pay for the cost of recommended vaccines and injectibles and for the administration of such vaccines and injectibles;
- Change its CPT reimbursement coding edits to comply with substantially all of the guidelines contained in the AMA CPT Manual;
- Not automatically reduce the intensity coding of evaluation and management codes billed for covered services;
- Disclose reimbursement edits and claims adjudication logic and conform its bundling and other computerized editing rules as specified above and, in greater detail, in the agreement;
- Ensure the payment of valid clean claims within fifteen (15) days for electronically-submitted claims and thirty (30) days for paper claims;
- Provide fee schedules via electronic communication;
- Establish a compliance dispute resolution mechanism to address disputes regarding Health Net's compliance with the agreement;
- Elimination of "all product" and "gag clauses" in provider contracts;
- Increase electronic claims submission – through investments to enhance the ability of physicians to pre-certify procedures, submit claims, check eligibility, check the status of claims and receive electronic remittance advices; and improve accuracy of information about eligibility of plan members;
- Establish a physician advisory committee;
- Recognition of valid assignments by plan members of plan benefits to physicians;

- Provide ninety (90) days notice of changes in practices and policies and annual changes to fee schedules;
- Where physicians are paid on a "capitation" basis, provide cost and utilization information, provide periodic reporting, and not delay assignment to the capitated physician.