Clinical Policy: Facility-Based Crisis Service for Children and Adolescents

Reference Number: WNC.CP.116
Last Review Date: 02/2025

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

Facility-Based Crisis Service for children and adolescents (ages 6-17) is a service that provides an alternative to hospitalization for an eligible Member who presents with escalated behavior due to a mental health, intellectual or development disability or substance use disorder and requires treatment in a 24-hour residential facility with 16 beds or less. Facility-Based Crisis Service is a direct and indirect, intensive short term, medically supervised service provided in a physically secure setting, that is available 24 hours a day, seven days a week, 365 days a year.

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover Facility-Based Crisis Service for Children and Adolescents when the Member:

A. Initial Criteria

1. Has a Mental Health or Substance Use Disorder diagnosis or Intellectual Developmental Disability as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), or any subsequent editions of this reference material based on the designation of the facility;
2. Meets American Society of Addiction Medicine (ASAM) Level 3.7 WM criteria as found in the current edition if the child's primary admitting diagnosis is substance use,
3. Is experiencing an acute crisis requiring short term placement due to serious cognitive, affective, behavioral, adaptive, or self-care functional deficits secondary to the DSM-5 diagnosis (es) which may include but are not limited to:
   a. Danger to self or others;
   b. Imminent risk of harm to self or others;
   c. Psychosis, mania, acute depression, severe anxiety, or other active severe behavioral health symptoms impacting safety and level of age-appropriate functioning;
   d. Medication non-adherence;
   e. Intoxication or withdrawal requiring medical supervision, but not hospital detoxification;
4. Has no evidence to support that alternative interventions would be equally or more effective, based on current North Carolina community practice standards

(such as Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, and American Society of Addiction Medicine); **and**

5. The Member has been determined to have no acute medical/psychiatric condition that requires a more intensive level of medical/psychiatric monitoring and treatment.

B. Continued Service Criteria

1. The desired outcome or level of functioning has not been restored, improved, or sustained over the timeframe outlined in the Member's service plan or the Member continues to be at risk for relapse based on history or the tenuous nature of the functional gains **or ANY** of the following applies:
   a. Member has achieved initial service plan goals and additional goals are indicated;
   b. Member is making satisfactory progress toward meeting goals;
   c. Member is making some progress, but the service plan (specific interventions) needs to be modified so that greater gains which are consistent with the Member's pre-crisis level of functioning are possible or can be achieved;
   d. Member is not making progress; the service plan must be modified to identify more effective interventions;
   e. Member is regressing; the service plan must be modified to identify more effective interventions; **or**

C. Discharge Criteria

1. The Member meets the criteria for discharge if **ONE** of the following applies:
   a. The Member has improved with respect to the goals outlined in the service plan and:
      i. Goals have been achieved **or**
      ii. The child has regained pre-crisis level of functioning **AND**
      iii. Discharge to a lower level of care is indicated.
   b. The Member is:
      i. Not benefiting from treatment; **or**
      ii. Not making progress in treatment; **or**
      iii. Is regressing **AND**
      iv. All realistic treatment options for this modality have been exhausted.

D. Exception

1. Per General Statutes 122C-261(f), 122C-262(d), and 122C 263(d)(2), if an individual with intellectual disabilities and a co-occurring mental illness is determined to need hospitalization, arrangements must be made for an inpatient admission to a non-state hospital in collaboration with WellCare of NC. All requests for an exception are determined by the Director of the Division of MH/DD/SAS or Designee.

E. Telehealth Services

1. Select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and

guidance in Clinical Coverage Policy **WNC.CP.193** *Telehealth, Virtual Communications, and Remote Patient Monitoring.*

II. It is the policy of WellCare of North Carolina® that Per 42 CFR 435.1009, Facility-Based Crisis Service for Children and Adolescents is **not medically necessary** when the Member:
- **A.** Is an inmate in a public correctional institution; **or**
- **B.** Is in a facility with more than 16 beds classified as an institution for mental diseases (IMD); **or**
- **C.** Is a child or adolescent stepping down from an inpatient level of care.

Background[1]

Under the direction of a psychiatrist, this service provides assessment and short-term therapeutic interventions designed to prevent hospitalization by de-escalating and stabilizing acute responses to crisis situations.

The Facility-Based Crisis Service includes professionals with expertise in assessing and treating mental health and substance use disorders and intellectual or developmental disabilities. The service must address the age, behavior, and developmental functioning of each Member to ensure safety, health, and appropriate treatment interventions.

The facility **must** ensure the physical separation of children (ages 6-11) from adolescents (ages 12-17) by living quarters, common areas, and in treatment. This separation may be accomplished by providing physically separate sleeping areas and by the use of treatment areas and common areas, i.e., dining room, dayroom, and in- and outside recreation areas, if age groups are scheduled at different times. If adults (18 years of age and older) and children and adolescents are receiving services in the same building, the facility must ensure complete physical separation between adults and children/adolescents.

I. Facility-Based Crisis Service components include:
- **A.** Assessments and evaluation of the condition(s) that has resulted in acute psychiatric symptoms, disruptive or dangerous behaviors, or intoxication from alcohol or drugs;
- **B.** Intensive treatment, behavior management support and interventions, detoxification protocols as addressed in the Member's treatment plan;
- **C.** Assessments and treatment service planning that address each of the Member's primary presenting diagnoses if the child is dually diagnosed with mental health and substance abuse disorders or mental health or substance abuse with a co-occurring intellectual developmental disability, with joint participation of staff with expertise and experience in each area;
- **D.** Active engagement of the family, caregiver or legally responsible person, and significant others involved in the child's life, in crisis stabilization, treatment interventions, and discharge planning as evidenced by participation in team meetings, collaboration with staff in developing effective interventions, providing support for and input into discharge and aftercare plans;

E. Stabilization of the immediate presenting issues, behaviors or symptoms that have resulted in the need for crisis intervention or detoxification;
F. Monitoring of the Member's medical condition and response to the treatment protocol to ensure the safety of the Member; **and**
G. Discharge planning.
1. Discharge planning begins at admission and shall include the Member, legally responsible person and WellCare of NC or delegated behavioral health care manager.
2. Discharge planning includes the following:
   a. Arranging for linkage to new or existing community-based services that will provide further assessment, treatment, habilitation, or rehabilitation upon discharge from the Facility-Based Crisis service;
   b. Coordination of aftercare with other involved providers, including the child's Primary Care Practitioner and any involved specialist for ongoing care of identified medical condition;
   c. Contact for re-entry planning purposes with the child's school or local school or Local Educational Authority as indicated;
   d. Arranging for linkage to a higher level of care as medically necessary;
   e. Identifying, linking to, and collaborating with informal and natural supports in the community; **and**
   f. Developing or revising the crisis plan to assist the Member and their supports in preventing and managing future crisis events.

II. Authorization Requirements: For authorization requirements, please refer to WellCare of North Carolina Authorization Lookup Tool; WellCare of North Carolina Medicaid Behavioral Health Authorization List; and WellCare of North Carolina Medicaid Behavioral Health Authorization Guidelines and FAQ, for details.

III. Service Order: A service order is required on the date of admission. A verbal order is acceptable; it must be received by a Registered Nurse and must be signed within 2 business days. The service order must be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner according to his or her scope of practice and must include a statement indicating that the service is medically necessary. The service order must be based on an individualized assessment of the Member's needs.

IV. Entrance Process - Involuntary evaluations and admissions must be processed in compliance with 10 A NCAC Subchapter 26C Section .0100 or substantially equivalent federal or Indian Health Services regulations.
A. The Facility-Based Crisis Service provider shall contact WellCare of NC to determine if the member is currently enrolled with another service provider agency that has first responder responsibilities or if the Member is receiving care coordination. If the Member is not already linked with a care coordinator, a referral should be made for

care coordination . These contacts should occur within 24 hours of admission into Facility-Based Crisis Service.

V. Expected Clinical Outcomes for this service are specific to recommendations resulting from the child's clinical assessment and to meeting the identified goals that assist the Member and his or her supports in:

- **A.** Reduction of acute psychiatric symptoms that precipitated the need for this service;
- **B.** Reduction of acute effects of substance use disorders with enhanced motivation for treatment or relapse prevention;
- **C.** Stabilizing or managing the crisis situation;
- **D.** Preventing hospitalization or other institutionalization;
- **E.** Accessing services as indicated in the comprehensive clinical assessment; **and**
- **F.** Reduction of behaviors that led to the crisis.

VI. Documentation Requirements, Provider Requirements, Provider Eligibility, Provider Qualifications & Occupational Licensing Entity Regulations, Provider Certifications, and Staff Training Requirements: For additional details, please refer to North Carolina Medicaid State Policy site for Facility-Based Crisis Services for Children and Adolescents Clinical Coverage Policy No: 8A-2 at: Program Specific Clinical Coverage Policies| NC Medicaid (ncdhhs.gov)

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025 American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS ®* Codes	Description	Telehealth Eligible	Billing Unit
S9484 HA	Crisis intervention mental health services, per hour	No	Units are billed in one-hour increments. Provider may bill up to 24 units per day, and bill for units of service provided on day of discharge

Provider(s) shall follow applicable modifier guidelines. The HA modifier is used with HCPCS code S9484 as noted above. HA indicates a child/adolescent program.

Note: As specified within this policy, components of this service may be provided via telehealth by the psychiatrist. Due to this service containing other elements that are not permitted via telehealth, the GT modifier is not appended to the HCPCS code to indicate that a service component has been provided via telehealth.

Note: Federally recognized tribal and Indian Health Service providers may be exempt from one or more of these items in accordance with Federal law and regulations and may be entitled to alternate reimbursement methodologies under Federal Law.

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original Approval date.	01/21	05/21
Revised criteria I.E., to "45 days in a 12-month period." Added criteria I.F. regarding Telehealth Services. Added "in-person or via telehealth" to Background II.C. Deleted "face-to-face" and added "in-person, telehealth" to Background IV.C.5. Revised psychiatrist staffing requirements in Background V.A. Deleted "on-site" and added "in-person or via telehealth" to Background VI.C. Added modifier and Telehealth Eligible column to HCPCS code grid. Added note with explanation of non-use of GT modifier.	08/21	11/21
Revised Background II.A. (added LPN) and Background IV.B.3.a. (removed “on-site”)	06/22	08/22
Annual Review. NCHC verbiage removed from NC Guidance Verbiage. Criteria I.A.2. verbiage rearranged with no effect on criteria. Criteria I.E., rephrased to, “In general, Facility Based Crisis Services should not exceed 45 days in a 12-month period, unless the member meets EPSDT criteria for additional service.” Background II.E. added Policy name WNC.CP.117 Outpatient Behavioral Health Services Provided by Direct-enrolled Providers, Background II.E. Note 3rd paragraph, added “is not already linked with a care manager, facility-based crisis staff is expected to make a referral to the appropriate entity (WellCare of NC, the member’s AMH/CIN, or LHD in the case of a child eligible for CMARC services) within 24 hours of admission into Facility Based Crisis Service.” Background II.E. Note 4th added, “Relevant diagnostic information must be obtained and included in the Member’s service plan.” Background V.A.1. added “unless an exception request is granted,” AND Deleted, “If a provider is unable to hire a board-eligible or board-certified Child Psychiatrist, the provider must seek an exception, with justification, from the PIHP. Background VI. Service Requirements, Added “The service must be provided in a facility which meets the criteria for and is licensed under 10A NCAC 27G.5000.” Background VII. Place of Service, Added, “A Facility-Based Crisis Service must be provided in a facility licensed by DHSR under 122C NCGA that is available at all times, 24 hours a day, 7 days	05/23	05/23

a week, and 365 days a year. A Facility-Based Crisis Service provider must meet the criteria for and be designated as a facility for the custody and treatment of involuntary clients under 10A NCAC 26C .0100."		
Replaced 'beneficiary' with 'member' throughout with no effect on criteria. Added link for "Behavioral Health I/DD Tailored Plan Memo on Eligibility and Enrollment Updates Feb. 2, 2021" Criteria I.A.2. verbiage rearranged with no effect on criteria. Criteria I.B.f. deleted "beneficiary is not improving, remains appropriate for the listed level of care, and would not be better served at an inpatient level of care" Criteria II added "Per 42 CFR 435.1009" Background II. Added 'Entrance Process - Involuntary evaluations and admissions must be processed in compliance with 10 A NCAC Subchapter 26C Section .0100." Background IV.E. Note 3rd paragraph, added, "a referral should be made for care management to WellCare of NC®, for care coordination. These member's contacts must occur within 24 hours admission into Facility-Based Crisis Service." Deleted "facility-based crisis staff is expected to make a referral to the appropriate entity" Deleted, "within 24 hours of admission into Facility Based Crisis Service." Background VII added "Provider Qualifications and Occupational Licensing Entity Regulations." Background VIII.A.1. Added, "If a provider is unable to hire a board-eligible or board-certified Child Psychiatrist, the provider must seek an exception, with justification, from WellCare of North Carolina®. Deleted "unless an exception request is granted." Background IX.A. Deleted "The service must be provided in a facility which meets the criteria for and is licensed under 10A NCAC 27G.5000." Background X. deleted "Place of Service"	08/23	08/23
Annual Review. Removed CPT and ICD-10 code boxes.	05/24	05/24
Under Description, added "(ages 6-17)" and deleted verbiage regarding 'enhanced service,' and associated link. Criteria I. text adjusted with no effect on criteria. Criteria I.A.2, added WM. Criteria I.D. changed 'mental retardation' to 'intellectual disabilities.' Background 3rd paragraph, added "(ages 6-11)" and "(ages 12-17)." Background II. Changed "Prior Authorization is not required for all units of Facility Based Crisis Services for Children and Adolescents," to "II. Authorization Requirements: For authorization requirements, please refer to WellCare of North Carolina Authorization Lookup Tool; WellCare of North Carolina Medicaid Behavioral Health Authorization List; and WellCare of North Carolina Medicaid Behavioral Health Authorization Guidelines and FAQ, for details." Moved Service Order to Criteria III, then III became IV. Etc. Deleted Criteria IV. Assessment & Evaluation requirements, V. Documentation Requirements, VI. Provider Qualifications and Occupational Licensing Entity Regulations, VIII. Staffing Requirements, IX. Service Requirements, and changed to Criteria V. "Documentation Requirements, Provider	12/24	12/24

Qualifications and Occupational Licensing Entity Regulations, Staffing Requirements and Service Requirements: For additional details, please refer to North Carolina Medicaid State Policy site for Facility-Based Crisis Services for Children and Adolescents Clinical Coverage Policy No: 8A-2 at: Program Specific Clinical Coverage Policies| NC Medicaid (ncdhhs.gov). Criteria IV.A. changed 'must' to 'should' and '24' to '72.' And deleted "Relevant diagnostic information must be obtained and included in the Member's service plan." Criteria VII. "Facility Based Crisis Services must be delivered by…," deleted.		
Background IV. Added "or substantially equivalent federal or Indian Health Services regulations." Background IV.A. changed 'management to coordination,' and 'manager to coordinator.' Deleted "management to WellCare of NC or the member's AMH/CIN for care coordination." Background IV.A. changed '72 to 24.' Under HCPCS code box, added "Note: Federally recognized tribal and Indian Health Service providers may be exempt from one or more of these items in accordance with Federal law and regulations and may be entitled to alternate reimbursement methodologies under Federal Law." Removed 'Medicaid and health choice" text from References.	02/25	02/25

References

1. State of North Carolina Medicaid Clinical Coverage Policy No: 8A-2 Facility-Based Crisis Service for Children and Adolescents. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov) Published January 1, 2025. Accessed January 24, 2025.

North Carolina Guidance

Eligibility Requirements

1. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
2. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
3. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

I. that is unsafe, ineffective, or experimental or investigational.
II. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

- If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
- **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:

NCTracks Provider Claims and Billing Assistance Guide:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

i. meet Medicaid qualifications for participation;
ii. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
iii. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

A. All applicable agreements, federal, state, and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

B. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

- Claim Type - as applicable to the service provided:
  Professional (CMS-1500/837P transaction)
  Institutional (UB-04/837I transaction)
  Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
- International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
- Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
  Unlisted Procedure or Service
  CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
  HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
- Modifiers - Providers shall follow applicable modifier guidelines.
- Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
- Co-payments -

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

- Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.