Valley Health Plan

2021 Provider Manual

For Employer Group, Covered California,
& Individual & Family Plan Members

February, 2021

Dear VHP Provider,

We are pleased to introduce Valley Health Plan's completely revised Provider Manual for 2021. This version of the Provider Manual is relevant for VHP's Commercial and Covered California plans.

VHP is dedicated to partnering with its providers in improving the health of its members and the community it serves. We believe that this version of the manual will improve efficiency and provide clarity into VHP's policies and workflows. This manual includes all the updated processes and procedures for working with VHP to provide health services to your patients, includes key points to improve claims and encounter data submissions and for the submission of appeals. Significant information has been added on medical management and pharmacy, among other revised chapters.

In addition, we have included a Quick Reference Guide that will give you and your team important VHP contact information. We have also included convenient links to the most frequently needed forms and tools for easy access and download of forms. With highlighted key points and an engaging design, we hope you will find this manual visually appealing and east to use.

We are currently working on a revised provider manual for our Medi-Cal line of business, and hope to release the new version by Spring of 2021. In the meantime, please access our 2020 Provider Manual for questions about providing services to Medi-Cal members, or contact Provider Relations at **1.408.885.2221**.

Thank you for the care and support you and your teams provide to VHP members. We look forward to partnering with you as we work to improving the health and wellness of our community.

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Valley Health Plan - Quick Reference Guide

Employer Group (Classic & Preferred), Covered California, & Individual & Family Plan

Resource	Contact
Website	**www.valleyhealthplan.org**
Mailing Address	**Valley Health Plan** **2480 N. 1st St., Suite #160** **San Jose, CA 95131**
Administration	Tel: **1.408.885.5780** Fax: **1.408.885.5921**
Appeals & Grievances Submission Address	**Valley Health Plan** Attn: **Appeals and Grievances** **P.O. Box 28387** **San Jose, CA 95159**
Claims Inquiries	Tel: **1.408.885.4563**
Claims Clearinghouse – Electronic Claims	Utah Health Information Network (UHIN) VHP's Trading Partner Number: HT007700-001 Customer Service Tel: **1.877.693.3071** VHP Payer ID: VHP01
Claims Submission Address – Paper Claims	**Valley Health Plan** **P.O. Box 26160** **San Jose, CA 95159**
Compliance, HIPPA, Privacy, Fraud, Waste & Abuse	Tel: **1.408.885.3749** Anonymous Hotline Tel: **1.855.888.1550**
Credentialing & Recredentialing	Tel: **1.408.885.2221**
Health Education	Tel: **1.408.885.3490** Fax: **1.408.954.1023**
Language Assistance (Interpretation, Translation, & Disability Access)	Tel: **1.408.808.6150** or **1.888.421.8444** TTY: Contact the California Relay by dialing **711** and providing the number **1.800.735.2929**

Member Eligibility	Tel: **1.888.421.8444**
Member Services	Tel: **1.888.421.8444** Fax: **1.408.885.4425**
Nurse Advice Line (24/7 Availability)	Carenet Health Systems Employer Group Tel: **1.866.682.9492** Covered California/IFP Tel: **1.855.348.9119**
Pharmacy Benefits Manager	Navitus Health Solutions, LLC Tel: **1.866.333.2757** Navitus Prior Authorization Fax: **1.855.878.9210**
Prior Authorization Submissions	Web Address: **https://www.vhpvalleyexpress.com/vhp/**
Prior Authorization, Utilization Management & Case Management	Tel: **1.408.885.4647** Fax: **1.408.885.4875**
Provider Contract Questions	Tel: **1.888.421.8444**
Provider Data Reporting & Validation Form Address	Valley Health Plan Attn: **Provider Data Management** **2480 N. 1st St., Suite #160** **San Jose, CA 95131**
Provider Relations	Tel: **1.888.421.8444** Tel: **1.408.885.2221** Fax: **1.408.793.6648**
Quality Management & Concerns	Tel: **1.408.793.6460** Fax: **1.408.885.3590**

VHP observes the following holidays:

- New Year's Day
- Martin L. King Day
- President's Day
- Cesar Chavez Day
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day
- Veteran's Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Day

CH 1:
Introduction

This Chapter Includes:

1. **About Valley Health Plan (VHP)**

2. **VHP's Vision, Mission, Goal, & Value**

3. **What is in this Provider Manual**

4. **Non-Discrimination Notice**

⚠	**Alert** Alert draws attention to critical information that has changed this year.
📞	**Contact** Contact information on who to contact for assistance.
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Welcome!

Welcome to Valley Health Plan (VHP). We value the contributions you make to assist us in improving the health and well-being of the communities and members we serve. VHP's priority is to promote healthy lifestyles through preventive health care. VHP works to accomplish this goal by partnering with you, the providers, who oversee the health care of VHP's members.

About Valley Health Plan (VHP)

Valley Health Plan is a health care service plan licensed under the Knox-Keene Heath Care Service Plan Act of 1975 by the Department of Managed Health Care (DMHC) and is dedicated to serving the populations of Santa Clara and portions of Monterey and San Benito Counties. Operating since 1985, VHP manages the care of Medi-Cal members, as well as those members enrolled in commercial products, such as Employer Group (Classic and Preferred), Covered California and Individual & Family Plan (IFP). VHP currently serves approximately 176,000 members. VHP is accredited by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) which demonstrates our commitment to quality health care. AAAHC is a private, non-profit organization formed in 1979 to assist ambulatory health care organizations to improve the quality of care.

VHP's ability to provide quality service is a result of leadership guided by our Vision, Mission, Values and Goal.

CH 1: Introduction

Our Vision

VHP will have a positive impact on the health of our **families, friends, and neighbors.**

Our Mission

To support the well-being of our members through a commitment to accessible, high-quality health services and community-focused, local care. We are committed to transforming the health of the community, one person at a time. Our mission is to provide better health outcomes at lower costs. We are driven by the following beliefs:

- **We believe** in treating the whole person, not just the physical body.
- **We believe** that treating people with kindness, respect and dignity empowers healthy decisions.
- **We believe** we have a responsibility to remove barriers and make it simple to get well, stay well and be well.
- **We believe** local partnerships enable meaningful, accessible healthcare.
- **We believe** healthier individuals create more vibrant families and communities.

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VHP strives to improve health status, foster successful outcomes, and attain high member and provider satisfaction. VHP's service model has been designed to achieve the following goals:

- Ensure access to primary and preventive care services

- Support care delivery in the best setting to achieve an optimal outcome

- Improve access to all necessary health care services

- Encourage quality, continuity, and appropriateness of medical and behavioral care; and

- Provide coverage in a cost-effective manner.

Our Goal

VHP's goal is to provide members access to high-quality care, to assure member satisfaction, to continually improve the partnership with our providers, to comply with all regulatory standards and to manage financial resources responsibly.

All of our programs, operating practices and policies and procedures are designed with our vision, mission, values, and goal in mind. We are happy to have you as part of our network and thank you for assisting us in achieving our mission.

Our Values

We…

- care about the total well-being of our members.

- show compassion and understanding for where each person is on their health journey.

- enhance our community by advocating for the diversity of individuals.

- embrace a commitment to ensuring that our members are treated with dignity and respect.

- form a lasting connection with our providers, brokers, and other partners to promote local business.

- strive for continuous improvement in the services we offer and satisfaction with the VHP experience.

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What is in this Provider Manual

VHP is committed to providing comprehensive information to providers about VHP's operations, programs and policies and procedures.

The information contained in this Provider Manual is relevant for individual providers, hospitals, physician groups, federally qualified health centers, medical groups, independent practice associations and their affiliated provider groups. All contracted, network providers serving the Employer Group (Classic and Preferred), Covered California and Individual & Family Plan are defined as a "provider" throughout this Provider Manual. As a contracted network provider you are responsible for adhering to the applicable requirements set forth in the Participating Provider Agreement, the member's Evidence of Coverage and the Provider Manual.

> The Provider Manual is intended for use by VHP's contracted, network providers serving Employer Group (Classic and Preferred), Covered California and Individual & Family Plan.

This Provider Manual contains policies, procedures, and guidelines for VHP's products by line of business (LOB):

Employer Group: Open to contracted employer groups for their employees who live or work in Santa Clara County.

Covered California: Open to residents living in Santa Clara County through the California Health Benefit Exchange.

Individual & Family Plan: Mirrored product to Covered California purchased directly through VHP for residents living in Santa Clara and portions of San Benito and Monterey Counties.

VHP has organized the Provider Manual to highlight subjects of greatest interest to providers, including, for example:

- Authorization and Referral Guidelines
- Claims and Billing Guidelines
- Eligibility Verification and Enrollment
- Pharmacy and Prescriber Information
- Services Covered or Administered by VHP
- Services Covered by Other Agencies

The Provider Manual is reviewed and revised on an annual basis or more frequently as needed. Providers will be notified when an updated version is effective. You can access the Provider Manual at **www.valleyhealthplan.org** or request a hard copy version by contacting VHP's Provider Relations Department at **1.408.885.2221**.

CH 1: Introduction

Non-Discrimination Notice

VHP complies with all applicable federal and state civil rights laws and does not discriminate on the basis of race, color, national origin, age, religion, sex, sexual orientation, gender expression, disability, or immigration status. VHP does not exclude people or treat them differently because of race, color, national origin, age, disability or sex, religion, sexual orientation, gender expression, or immigration status.

VHP provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats). Additionally, VHP provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If a member needs these services, please have them contact VHP's Member Services Center at: **1.888.421.8444** (For TTY, contact California Relay by dialing **711 or 1.800.735.2929**). If a member believes that VHP has failed to provide these services or has been the subject of discriminated on the basis of race, color, national origin, age, religion, sex, sexual orientation, gender expression disability, or immigration status they can file a grievance by calling the number above and asking for help filing a grievance.

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CH 1: Introduction

CH 2:
Resources for Providers

This Chapter Includes:

!	**Alert**	Alert draws attention to critical information that has changed this year.
📞	**Contact**	Contact information on who to contact for assistance.
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Getting Assistance from VHP

> When you have questions or need assistance, we encourage you to first use the many resources that are available for providers on VHP's website: **www.valleyhealthplan.org/providers**.

Accessing VHP's website can significantly reduce the number of telephone calls you make to VHP. The website allows immediate access to current provider and member information 24 hours a day, seven days a week. On the provider website, you can find information about:

- Provider Billing/Claims Submission

- Forms and Resources
    - Provider Manual
    - Authorizations and Referrals
    - Case Management
    - Evidence of Coverage
    - Clinical Guidelines

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    - Training

    - Dispute and Grievance Form

    - Provider Directory Online Verification and Change Form

    - And many more resources

- How to Join VHP networks

- Pharmacy Information

If you are not able to locate answers to your questions using VHP's online provider resources and this Provider Manual, you can also contact VHP's Provider Relations staff at **1.408.885.2221** (For TTY, contact California Relay by dialing **711**), available Monday – Friday from 8:00 am to 5:00 pm (Pacific) to answer questions or provide other assistance. When calling VHP, please have the following information available:

- National Provider Identifier (NPI)

- Tax Identification Number (TIN)

- VHP Member Identification Number

Provider Relations Department

VHP's Provider Relations Department is dedicated to making each provider's experience with VHP a positive one. Provider Relations is responsible for oversight, coordination or initiation of the services listed below:

- Conducting physician and office staff initial and ongoing education (Initial training occurs within ten business days of a provider's active status in VHP's core operating system, QNXT);

- Conducting hospital, facility and ancillary provider initial and ongoing education and training;

- Distributing Provider Manuals and similar provider reference materials. As noted above, the Provider Manual is available on VHPs website (**https://www.valleyhealthplan.org/sites/p/ Pages/Providers.aspx**) and is generally distributed no later than seven calendar days after the provider requests a hard copy from the Provider Relations Department;

- Providing assistance with claims inquiries, electronic submission of claims and other administrative services;

- Providing assistance with installation, functional training and securing access to web-based tools, including completing access request forms for VHP's referral authorization system;

- Distributing notices, bulletins, newsletters, and other information related to VHP's programs, processes or policy updates or changes;

- Facilitating completion of forms, including electronic funds transfer or Automated Clearing House (ACH) and W-9 or other required tax forms;

- Conducting "secret shopper" evaluations to assess compliance with VHP's timely access, availability, or other regulatory requirements;

- Conducting on-site facility reviews, which are generally conducted during the initial credentialing process, and periodically as needed or required;

- Scheduling periodic meetings to resolve issues and identify opportunities to improve VHP's service to its providers, or

- Providing information on provider performance with respect to quality indicators measured by VHP and engagement of provider office staff in quality improvement activities.

As a participating provider in VHP's network, you and your office staff have a dedicated Provider Relations Specialist (PRS) who is your resource to provide education and training regarding VHP's administrative and regulatory requirements. The PRS is expected to communicate with you or your designated office manager on a routine basis. The PRS conducts regularly scheduled outreach activities as a proactive way to:

- Build a positive relationship with you and your staff.

- Identify issues, trends, or concerns quickly.

- Answer questions.

- Share new information regarding VHP.

- Discuss changes within your practice such as changes in office staff, new location, or scope of service.

You may contact your PRS to:

- Report any change to your practice (i.e., practice or pay-to TIN, NPI, name, phone numbers, fax numbers, practice location, address, language capabilities, addition or termination of providers, or patient acceptance status (i.e., open/closed panel).

> ⓘ **Please note:** Updates of changes in your language capabilities or that of your office staff must be communicated to VHP on an annual basis.

- Initiate credentialing of providers who are new to the practice.

- Schedule an in-service training for new staff.

- Conduct on-going education for existing staff.

- Obtain clarification of state and health plan policies, procedures and/or contract language.

- Learn about special programs available for members and/or providers.

- Request fee schedule information.

- Ask questions regarding your membership assignment list (patient panel) or capitation payments, as applicable.

- Receive assistance related to claims or encounter submissions.

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- Learn how to use electronic solutions for web authorizations, claims submissions or checking member eligibility.

- Provide recommendations for enhancements to VHP's participating provider network to maintain consistency with specialist, ancillary and post stabilization referral and utilization preferences and practices.

Another key responsibility of the Provider Relations Department is to continuously monitor network adequacy to ensure that VHP members have access to care that mirrors community access standards and to maintain compliance with VHP and DMHC access standards. Your PRS will keep you and your staff apprised of network changes, provider additions or terminations, or to discuss your needs for specific types of providers within the geographic area you serve.

Notification of Practice or Demographic Change Requirements

> (!) To help VHP maintain an accurate Provider Directory and claim payments, it is important
> that you or your designated office staff proactively notify your PRS at least 30 days prior to any changes to your practice. You can access the Provider Directory Online Verification and Change Form on VHP's website using the following link:
> **www.valleyhealthplan.org/sites/p/Pages/Provider-directory-change-form.aspx**

For more routine demographic changes, you or your office staff can access the Provider Directory Online Verification and Change Form on VHP's website using the following link:
 www.valleyhealthplan.org/sites/p/Pages/Provider-directory-change-form.aspx

Examples of the types of information providers must submit to VHP to allow for the verification and maintenance of VHP's Provider Directory include:

1. The provider's name

2. The provider's practice location or locations

3. The provider's contact information

4. The provider's office hours by day of the week

5. Type of practitioner (PCP, Specialist, etc.)

6. NPI

7. California license number and type of license

8. For physicians, the American Board of Medical Specialty designation and subspecialty, including board certification, as applicable

9. For advanced practice providers, specialty designation, including any board certification

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10. The provider's office email addressThe provider's office fax number

11. The name of each VHP contracted affiliated provider group in which the provider sees members

12. A listing for each of the following provider types that are under contract with VHP, such as:

    – **For physicians and surgeons:** The name of the provider group and the name(s) of the hospital(s) or ambulatory surgery center(s) at which the physician has admitting privileges. Admitting privileges at a VHP contracted hospital or ambulatory surgery center is a prerequisite for participation in VHP's network.

    – Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, nurse midwives, and dentists.

    – **For Federally Qualified Health Centers (FQHC), rural health center (RHC) or primary care clinics:** the name of the FQHC, RHC or clinic.

        a. For any provider described in subparagraph (a) or (b) above who is employed by an FQHC, RHC or primary care clinic, and to the extent their services may be accessed and are covered through the contract with VHP, the name of the provider and the name of the FQHC, RHC or clinic is required.

        b. Facilities, including but not limited to general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, and inpatient rehabilitation facilities.

        c. Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.

If any of the above information changes, notify VHP by contacting Provider Data Management at **1.408.885.2566** or email **ProviderDataMgt@vhp.sccgov.org** or use the Provider Directory Online Verification and Change Form located on VHP's website:

www.valleyhealthplan.org/sites/p/Pages/Provider-directory-change-form.aspx

All other changes require 30 day advance written notice. When provider demographic updates are submitted, please list only the address(es) where a member was able to make an appointment to see the departing or terminating provider.

On-call, locum tenens and substitute providers who are not regularly available to provide covered services at an office or practice location, should not be listed at that address.

Provider Directory Audit

All provider and medical groups are obligated to participate in VHP's annual provider directory audit to verify the accuracy of the provider contact and profile information in VHP's Provider Directory.

Non-responsive providers may be removed from VHP's Provider Directory until their information is submitted and verified as accurate.

Providers should direct members to VHP's Member Services Call Center at **1.888.421.8444** for any assistance or questions related to the Provider Directory.

Termination of Provider-Patient Relationship (or Termination of Patient Care)

Once the provider-patient relationship is established, the provider must continue to provide care to the patient to avoid allegations of abandonment until one of the following occurs:

- The patient terminates the provider-patient relationship.
- The provider-patient relationship is terminated by mutual consent.
- The patient's condition no longer requires the care of this particular provider.
- The provider agrees to treat only a specific condition or agrees to treat only at a specific time or place.
- The provider terminates the provider-patient relationship by notifying the patient in writing of withdrawal from care after a specific time which is stated in the letter. The patient is also given information necessary to obtain their medical records or transfer to another provider.

According to the American Medical Associations Council on Ethical & Judicial Affairs, a physician may not terminate a patient relationship as long as further treatment is indicated without sufficient time to make other arrangements for necessary care. Additionally, in the rare situation of an acute episode of illness, the transfer of care may be physician to physician to avoid any lapse in continuity of care.

When a provider withdraws from a member who needs continuity of care at that time, the provider must complete all of the following steps:

1. Give the member reasonable notice (30 days, in most cases) of their intent to withdraw from providing services or care.

2. Provide the member with a reasonable amount of time (30 days, in most cases) to find alternative services.

3. Continue to be available during the transition period to treat the member up and until the date indicated in the notice of termination to the member.

Note: The same rules apply to termination of health care services for nonpayment of fees.

Reasonable Notice

In most cases, a 30-day advance notice would be considered reasonable for member termination. If the basis for termination of a VHP member is for disruptive behavior, and/or behavior that is dangerous to other members or staff, the period may be shortened to as little as one day. This change to VHP's normal notification process is dependent upon the seriousness of the threat and VHP's ability to either terminate the member from VHP or to locate another provider to accept the member. This process will also take into consideration both the severity of the member's condition and the availability of other providers within the time-period selected. It is not necessary to indicate to the member why the relationship is being terminated.

Note: Notify VHP's Member Services Call Center of the termination at the same time you notify the member at **1.888.421.8444** or by sending a fax to **1.408.885.4634**.

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CH 2: Resources for Providers

CH 3:
Enrollment & Elligibility

This Chapter Includes:

Alert
Alert draws attention to critical information that has changed this year.

Contact
Contact information on who to contact for assistance.

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VHP offers several Health Maintenance Organization (HMO) products to the County of Santa Clara (County) employees and their dependents and through the Covered California Health Benefit Exchange (CoCA), including the Off-Exchange Individual and Family Plan (IFP) product. An HMO is a specific type of health care services plan that requires that a member select a PCP to coordinate care and includes a specified network where services can be obtained. A member's specified network is prominently displayed on the member ID card and noted as "Network." A member is assigned a Network based on the PCP's affiliation with a medical group/independent practice association (IPA) or alternatively, based on the direct independent network contract the PCP has with VHP. **Except for urgent or emergent services or when services are not otherwise available in the member's Network, services should be referred to providers affiliated with the member's chosen Network.** Below are the details for VHP's commercial lines of business (LOB) and plans:

VHP's four commercial, HMO products

Employer Group - Classic: Open to contracted employer groups for their employees who live or work in the County.

Employer Group - Preferred: Open to contracted employer groups for their employees who live or work in the County. The Preferred product has a narrower network of providers than the Classic product.

Covered California: Open to residents living in the County through the California Health Benefit Exchange.

Individual & Family Plan: Mirrored product to CoCA purchased directly through VHP and open to residents living in the County and portions of San Benito and Monterey counties.

For VHP's Commercial Group – Classic and Preferred and IFP plans an enrollment application must be completed during the initial enrollment period. For CoCA, VHP receives a daily 834 file from the California Health Benefits Exchange.

For Employer Group (Classic and Preferred) and IFP, the member's choice of a PCP can be included on the enrollment application. If an invalid PCP or no PCP is selected, the member will be assigned to the PCP with the closest proximity to the member's home address and based on the member's language preference designation.

Employer Group
Employer Group members are eligible to apply for coverage if they meet the eligibility criteria below:
- Live or work in the County;

- Satisfy the Employer Group's waiting period requirements; and
- Meet the Employer Group's eligibility requirements as determined by the employer.

Covered California and Individual & Family Plan

On and Off-Exchange members are eligible to apply for coverage under VHP through Covered California (CoCA) or directly from VHP for the mirrored IFP product if they meet the following definition:

1. Live in the County (CoCA) or live in the County and portions of San Benito and Monterey counties (IFP);
2. Are not enrolled in any other health coverage, including Medicare or Medi-Cal;
3. Submit a written application and first premium payment prior to the effective date of coverage; and
4. Have completed an application that has been approved by VHP for the effective date of coverage.

Eligibility Grace Period for Covered California Members and Individual & Family Plan Members

When individuals enroll in a health benefit plan through the California Health Benefit Exchange (also known as Covered California or CoCA), VHP is required to provide a three-month grace period before terminating the member's coverage.

Subsidized Members

The grace period applies to those who receive federal and state subsidy assistance in the form of an advanced premium tax credit (APTC) or state subsidy, and who have paid their first full month's premium within the benefit year. You can verify if the member is within the grace period when you verify eligibility. If the date of service occurs after the "paid through date," then the member is in the grace period. They are at risk of retroactive termination if the premium is not paid in full at the end of the three-month period.

If a member fails to pay their premium at the end of the three-month grace period, the member will be disenrolled due to exhausting the grace period. Capitation paid during their eligible grace period may be recouped back during the following month's capitation payment as part of the reconciliation process. For fee-for-service (FFS) claims paid to the provider during this time, VHP will recoup such FFS payments through the claims overpayment process (further detail are available in Chapter 13, "Claims Overpayments").

Non-Subsidized Members

For members who do not qualify for advanced premium tax credit (APTC) or state subsidy, the grace

period for those Members is one month. This rule pertains to CoCA and IFP members.

Verifying Eligibility and Benefits

Verification of a member's eligibility prior to rendering care helps to:

- Ensure that you submit the claim to the correct health plan;

- Allow you to collect copayment, coinsurance and/or deductible amounts, if applicable;

- Determine if a referral and prior authorization or notification is required;

- Reduce claims payment denials for non-coverage; and

- Identify the potential for other health coverage.

One of the primary reasons for claims rejections is incomplete or inaccurate eligibility information.

For eligibility verification for commercial members, the provider may:

- Refer to Valley Express (VE), VHP's online referral authorization and eligibility system for an electronic eligibility verification at **https://www.vhpvalleyexpress.com/vhp/;**

- Contact VHP's Member Services Call Center for verbal eligibility verification Monday through Friday, 8:00 am to 5:00 pm (Pacific) at **1.888.421.8444**; or

- Check the most current monthly eligibility report sent via Secure File Transfer Protocol (SFTP) reflecting members assigned to PCPs' affiliated with medical groups/IPAs.

When verifying insurance eligibility, use the member's information located on the front of the identification (ID) card:

- Member's name

- Date of birth

- Member Identification (ID) number

In addition to the information noted above, to verify eligibility the provider will also need the member's current address.

Online Verification of VHP Member Eligibility

Providers verify eligibility online by logging into VHP's referral management system, Valley Express at **https://www.vhpvalleyexpress.com/vhp/.**

Step 1 – **In order to access Valley Express, each provider must complete the Valley Express Access Request form, which can be found online at https://www.valleyhealthplan.org/sites/g/ files/exjcpb771/files/ve-ext-access-req-frm.pdf**.

For more information or questions regarding completion of the Valley Express Access Request form, contact Provider Relations at **1.408.885.2221**.

Step 2 – Log into the Valley Express referral management system.

Step 3 – On the left-hand side, select "Inquiry" and then select eligibility.

Or alternatively, eligibility verification can be accessed from the Valley Express Main Menu.

MAIN MENU

Please select from the following list:

- Inquiry
    - Eligibility (Look up member)
    - Display current member
    - Display Authorizations (Look up authorizations for current member)
    - Search Authorizations (Search based on date, number, etc)
    - Provider
    - Diagnosis
    - Procedure

Step 4 – Fill out the fields below and follow the prompts.

For providers affiliated with Santa Clara Valley Medical Center, member eligibility can be verified with the VMC Medical Record Number and the VHP ID number, which is located on the front of the member's ID card. See later in this chapter for sample ID cards for those plans offered by VHP. For all other providers, verify eligibility by entering the member's demographic information reflected below.

SEARCH ELIGIBILITY

OPTION I: SEARCH BY MEMBER ID

VMC Medical Record Number: [ ]
HealthPlan ID. [ ]

[SEARCH]

OPTION II: SEARCH BY MEMBER DEMOGRAPHICS

Last Name: [ ]   First Name: [ ]
DOB: [ ] (mm/dd/yyyy)
Health Plan: [-- All HealthPlans -- ⌄]
PCP: [ ]   [LOOKUP PCP]
Network: [-- All Networks -- ⌄]

[SEARCH]

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CH 3: Enrollment & Elligibility

Following the search, the information noted below will be made available to the provider.

SELECTED MEMBER

[View authorizations] [Search authorizations] [View eligibility history] [View Appointments]

MEMBER DEMOGRAPHICS

Name	
Date of Birth	
Sex	
Address / Phone	
Network	
PCP	
PCP Eff Date	

PLAN INFORMATION

Health Plan Name	
Effective Date	
Termination Date	
HealthPlan ID	
Plan Group	

If unable to verify eligibility, contact VHP's Member Services Call Center for verbal eligibility verification Monday through Friday, 8:00 am to 5:00 pm (Pacific) at **1.888.421.8444**.

VHP Member ID Cards

All new VHP members receive a VHP member ID card. VHP's ID cards include at a minimum the following information:

- Member name
- Member ID number
- The PCP's name and telephone number (when available)
- Pharmacy contact information
- Member Services Call Center contact information

Information on the ID cards may vary by plan. Please check the member's ID card at each visit. A second form of identification should also be requested at the time of the visit. Keep a copy of both sides of the ID card and the secondary form of identification for your records. **Possession of an ID card is not proof of**

CH 3: Enrollment & Elligibility

eligibility. VHP will deny payment for health care services rendered to ineligible members.

For VHP's Employer Group Classic and Preferred plans, a new ID card is issued only when a member reports a lost card, has a name change, requests a new PCP or as a result of changes to the information reflected on the front or back of the ID card.

CoCA and IFP members will receive a new member ID card every year. **Since member ID cards are not a guarantee of eligibility, providers must verify eligibility on each date of service.**

Member Cost Share

Depending on the CoCA or IFP plan, a member may be responsible to share in the cost for services provided. Copayments, coinsurance, and deductibles are referred to as "Member Cost Share." These fees are the member's responsibility to pay for certain covered services. Providers are responsible for collecting the Member Cost Share at the time of visit in accordance with the member's benefit plan. VHP's reimbursement to the provider will be the contractual allowable **minus** the Member Cost Share. In other words, VHP's reimbursement to the provider will assume that the member's payment responsibility has been satisfied. Member Cost Share varies by plan and should be verified at the time of service. The Member Cost Share is included in the member's Evidence of Coverage (EOC) which is located on VHP's website at **https://www.valleyhealthplan.org/**. It is also located on the front of the ID card. If no Member Cost Share is noted on the front of the member's ID card, the provider may assume that the member has no financial responsibility for the services to be provided. Select the EOC for the plan which is noted on the member's ID card. See later in the chapter for the location of the plan on the ID cards.

For additional assistance with determining Member Cost Share, contact VHP's Members Services Call Center at **1.888.421.8444**, Monday to Friday, 8:00 AM to 5:00 PM (Pacific).

> **Note:** Not all providers are contracted to render services to members for each VHP plan. Provision of services to a member in a plan for which the provider is not contracted, may result in reduction or denial of claim payment and may limit the provider's ability to balance bill the member.

CH 3: Enrollment & Elligibility

Valley Health Plan

Sample ID Cards

Employer Group - Classic & Preferred Plans

Front Side
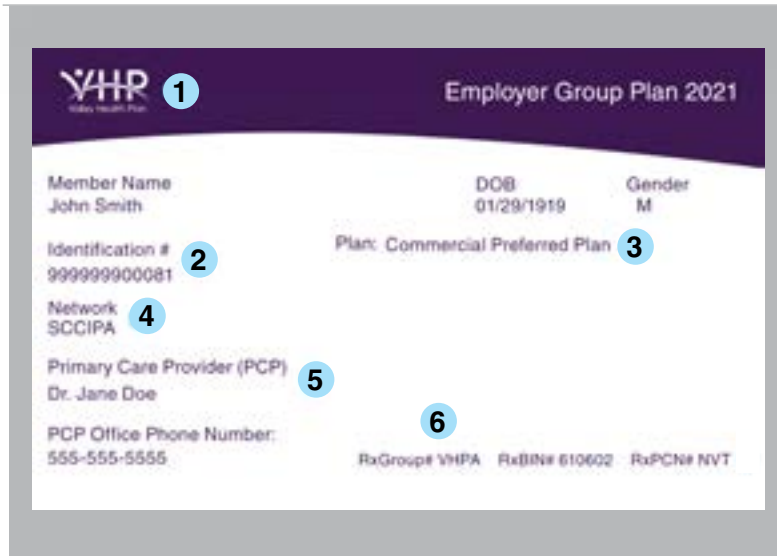
1. **VHP Brand:** Identifies VHP as the member's health plan.

2. **Identification #**: Member's unique identification with VHP.

3. **Plan:** Identifies the applicable benefit plan name. Different plans may have different co-pays, co-insurance, deductibles and provider networks.

4. **Network:** Identifies the network of providers to which the member has been assigned. Members should be referred in-network, except as described in this Provider Manual.

5. **Primary Care Provider:** Member's assigned primary health care provider.

6. **Rx Group #:** Information required for prescription claims processing
Rx Bin #:
RxPCN #:

Back Side
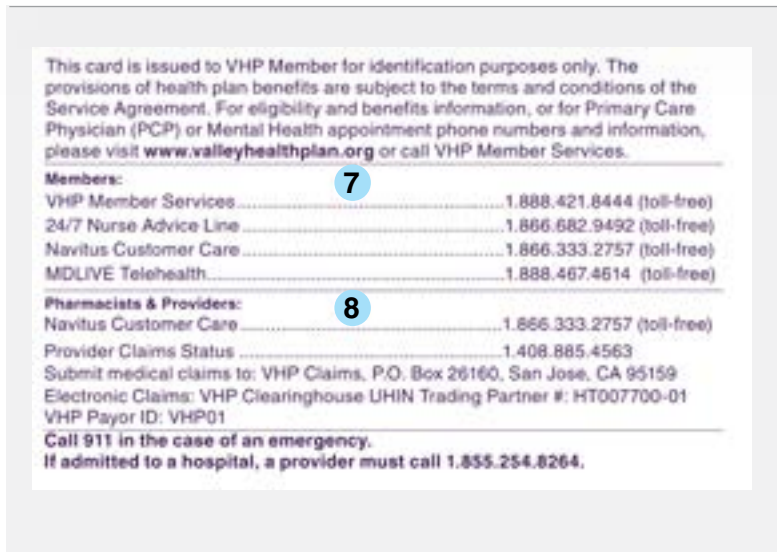
7. **Member Section:** Lists benefit plan contact numbers for members.

8. **Pharmacist and Provider Section:** Lists the PBM contact number and claims submission information.

*As identified in the Evidence of Coverage for the specific VHP benefit plan.

CH 3: Enrollment & Elligibility

Sample ID Cards
Covered California Plan

Front Side
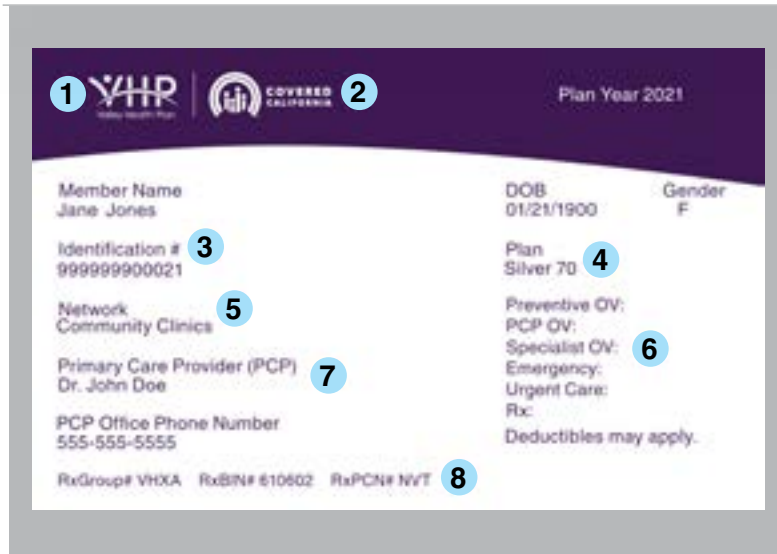
1. **VHP Brand:** Identifies VHP as the member's health plan.

2. **Covered California Brand:** Identifies that member has coverage through Covered California

3. **Identification #:** Member's unique identification with VHP.

4. **Plan:** Identifies the applicable benefit plan name. Different plans may have different co-pays, co-insurance, deductibles and provider networks.

5. **Network:** Identifies the network of providers to which the member has been assigned. Members should be referred in-network, except as described in this Provider Manual.

6. **Preventive OV:** The co-payment required, if any, for plan benefits.*
PCP OV:
Specialist OV:
Emergency:
Urgent Care:
Rx:

7. **Primary Care Physician:** Member's assigned primary health care provider.

8. **Rx Group #:** Information required for prescription claims processing
Rx Bin #:
RxPCN #:

Back Side

9. **Member Section:** Lists benefit plan contact numbers for members.

10. **Pharmacist and Provider Section:** Lists the PBM contact number and claims submission information.

*As identified in the Evidence of Coverage for the specific VHP benefit plan.

CH 3: Enrollment & Elligibility

Valley Health Plan

Sample ID Cards
Individual & Family Plan

Front Side
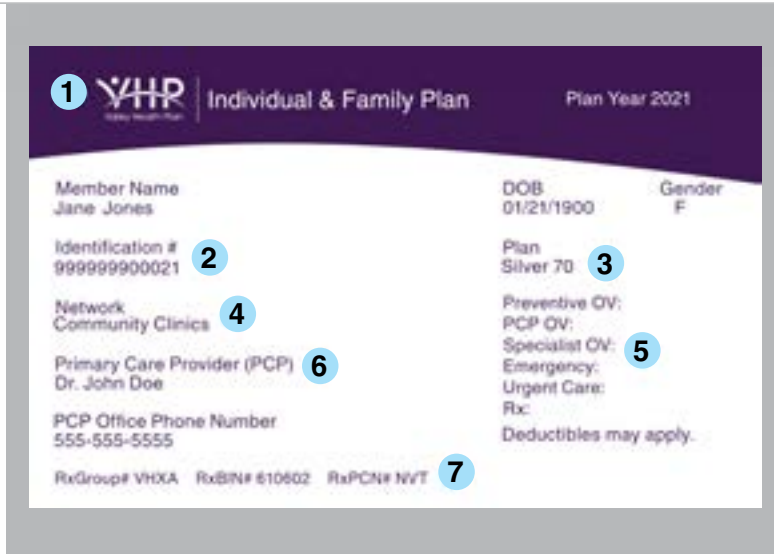
1. **VHP Brand:** Identifies VHP as the member's health plan.

2. **Identification #:** Member's unique identification with VHP.

3. **Plan:** Identifies the applicable benefit plan name. Different plans may have different co-pays, co-insurance, deductibles and provider networks.

4. **Network:** Identifies the network of providers to which the member has been assigned. Members should be referred in-network, except as described in this Provider Manual.

5. **Preventive OV:** The co-payment required, if any, for plan benefits.*
PCP OV:
Specialist OV:
Emergency:
Urgent Care:
Rx:

6. **Primary Care Physician:** Member's assigned primary health care provider.

7. **Rx Group #:** Information required for prescription claims processing
Rx Bin #:
RxPCN #:

Back Side

8. **Member Section:** Lists benefit plan contact numbers for members.

9. **Pharmacist and Provider Section:** Lists the PBM contact number and claims submission information.

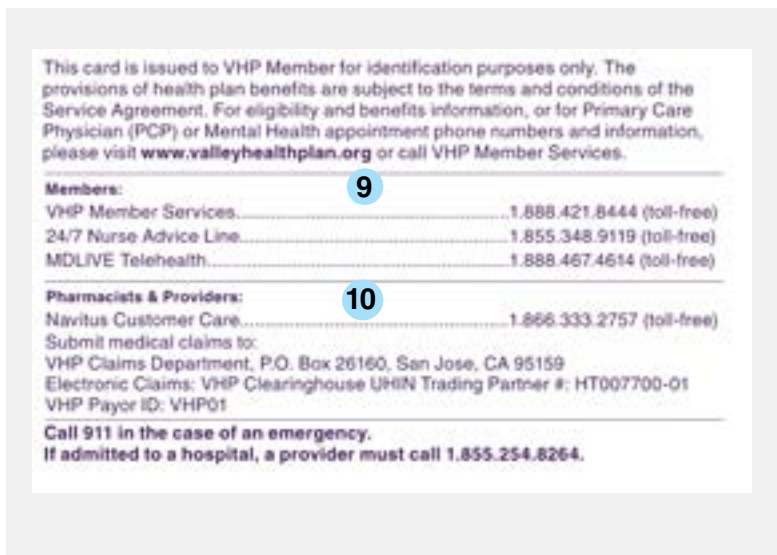*As identified in the Evidence of Coverage for the specific VHP benefit plan.

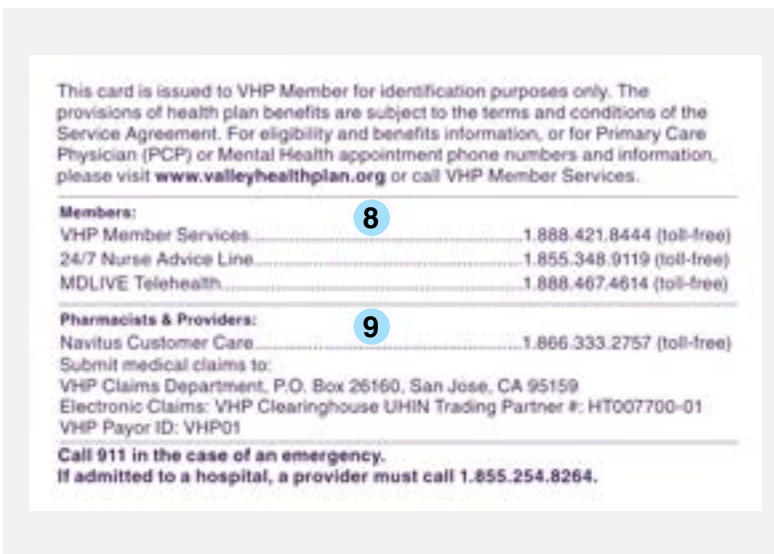**CH 3: Enrollment & Elligibility**

Valley Health Plan

EDI: Enrollment and Eligibility (834) and Response (999 & TA1)

The Health Insurance Portability and Accountability Act (HIPAA) requires all health insurance companies to comply with the Electronic Data Interchange (EDI) standards for health care as established by the Department of Health and Human Services (HHS).

The EDI 834 transaction allows you to obtain members' eligibility and benefit information in a scheduled "real-time" format. The HIPAA 834 format is the only acceptable format for this EDI transaction. The EDI 834 has been specified by HIPAA 5010 standards for the electronic exchange of member enrollment information, including benefits, plan subscription and member demographic information. The 834 transactions may be used for any of the following functions:

- New enrollments

- Changes in a member's enrollment

- Reinstatement of a member's benefit enrollment

- Disenrollment of members (i.e., termination of plan membership)

VHP will pass the following health care transaction types to PCPs, medical groups/IPAs and other medical trading partners that render services to VHP's members, such as MDLive and Carenet:

- 834 Membership Enrollments

Providers will pass the following health care transaction types back to VHP:

- 999 Functional Acknowledgments

- TA1 Interchange Acknowledgments

File naming conventions:

Transaction Type	Frequency	Type
834	Daily, Weekly, Monthly, Or specified date	Outbound
999	Daily, Weekly, Monthly, Or specified date	Inbound
TA1	Daily, Weekly, Monthly, Or specified date	Inbound

Note: "Inbound" and "Outbound" are from the VHP perspective, which means that "Inbound" **to** VHP and "Outbound" **from** VHP. File names are case sensitive.

CH 3: Enrollment & Elligibility

Valley Health Plan

Eligibility and Capitation Reports

VHP will provide the eligibility and capitation reports (when relevant) which contain the eligibility addition and termination updates and capitation details in an electronic format. Receiving eligibility information electronically enables providers or medical groups/IPAs to use and sort the information to meet their specific reporting needs.

The eligibility reports are distributed via VHP's clearinghouse, Utah Health Information Network (UHIN) and capitation reports are transmitted via VHP's SFTP to applicable providers or medical groups/IPAs on the agreed upon schedule. For details on the file formats, refer to section in this Chapter entitled "EDI: Enrollment and Eligibility (834) and Response (999 & TA1).

Provider Entities Delegated for Administrative and/or Clinical Services

If a provider is affiliated with an independent practice association (IPA), medical group, or other organized provider entity that has been delegated responsibility by VHP to provide administrative and/or clinical services to VHP's members, eligibility and/or capitation reports and payments may be distributed to the provider by the delegated entity through which care is provided to VHP members.

Refer to **Chapter 22, "Delegated Entities"** for additional information. Conformance with VHP's policies, procedures, VHP's Provider Manual, protocols, and all applicable regulatory and accrediting standards is required.

CH 4:
Member Benefits, Exclusion, & Limitations

This Chapter Includes:

1. **Member Benefit Plans**

2. **Network Development & Maintenance**

3. **Tertiary Care**

(!)	**Alert** Alert draws attention to critical information that has changed this year.
📞	**Contact** Contact information on who to contact for assistance.
VHP	**Book Table of Contents** Click the purple VHP circle logo, located at the bottom left corner, to return to the main TOC.

VHP network providers render a variety of health care services pursuant to the benefit limitations and exclusions reflected in the member's Evidence of Coverage (EOC). You can find the EOCs for the Covered California/IFP and the Employer Group Lines of Business on the VHP website at **https://www. valleyhealthplan.org/sites/m/mm/Pages/evidenceofcoveragebookletanddisclosureform.aspx.** For specific benefits questions or assistance, please contact Member Services at **1.888.421.8444**.

(!) Providers need to validate VHP Commercial Employer Group, Covered California and Individual & Family Plan member eligibility and benefits prior to rendering services to VHP members. To confirm a VHP member's eligibility, please refer to the Valley Express online eligibility system available at **https://www.valleyhealthplan.org/sites/p/fr/auths/Pages/home.aspx** or contact VHP's Member Services Department Monday through Friday, 8 am to 5 pm (Pacific) at **1.888.421.8444**.

If you do not have access to the online system, and you wish to obtain access to Valley Express to verify eligibility, please call Provider Relations at **1.408.885.2221**. A copy of the VE Access Form is included in the **Appendix**.

Disclaimer: Members must present their VHP identification card whenever they seek services. Providers must check eligibility at each visit. Possession of a VHP ID card does not guarantee eligibility or payment.

Member Benefit Plans

(!) **Employer Group Plan (Classic and Preferred):** Members are not responsible for any cost sharing for covered services unless specified (e.g., cost share applies to acupuncture and chiropractic care). Refer to the member's EOC at **https://www.valleyhealthplan.org/sites/g/ files/exjcpb771/files/VHP-Employer-Group-EOC-2020-Final.pdf**

Covered California and Individual & Family Plan: Members are responsible for deductibles, coinsurance, and copayments, which apply to many covered services. Refer to the member's EOC at **https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/2021-CoveredCalifornia-IFP-EOC.pdf**

(!) The following list is not intended to be an all-inclusive list of covered and non-covered benefits. All services are subject to benefit coverage, limitations, and exclusions as described in the EOC. Some services require prior authorizations before services are rendered. For more information on services requiring prior authorization, see Chapter 17, "Utilization Management" for additional information.

	Covered		Not Covered

Benefits	CC & IFP	EG	Details and Limitations
Abortion	✓	✓	Refer to "Family Planning" in the EOC.
Acupuncture	✓	✓	Acupuncture services are provided for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain. Services are available within VHP's contracted provider network and may be authorized through the member's PCP or other VHP contracted providers. In the event services require more than 20 prescribed visits per calendar year, justification is required from the requesting provider.
Allergy Testing	✓	✓	Allergy testing and treatment including serum and injection services are covered.
Bariatric Surgery	✓	✓	Provided for the treatment of morbid obesity when medically necessary.
Clinical Trials	✓	✓	Coverage is limited to routine patient care costs in accordance with State and Federal regulations. Covered services are only available if: • Member has been diagnosed with cancer or other life-threatening disease or condition; • Member is accepted into a Phase I through Phase IV clinical trial; or • VHP's contracted provider has recommended member's participation in the trials because it will have a meaningful potential benefit to the member.
Chemotherapy, Radiation	✓	✓	

Valley Health Plan

CH 4: Member Benefits, Exclusions, & Limitations

	Covered		Not Covered
✓	Covered	✗	Not Covered

Benefits	CC & IFP	EG	Details and Limitations
Chiropractic Care	✗	✓	**Employer Group Members – Covered** Services are available within VHP's network of contracted providers and may be authorized through the member's PCP or other VHP contracted provider. Coverage is limited to a maximum of 20 prior authorized visits per calendar year. In the event services require more than 20 prescribed visits per calendar year, justification is required from the requesting provider. Services, which are not chiropractic related such as x-rays or nutritional counseling, are not covered benefits and will not be reimbursed by VHP.
Cosmetic Surgery	✗	✗	Except for medically necessary cosmetic surgery or plastic surgery as specified under the EOC section "Mastectomies and Lymph Node Dissections," cosmetic surgery and plastic surgery are excluded from coverage by VHP.
Contraceptive Methods	✓	✓	Coverage includes diaphragms, cervical caps, contraceptive rings, contraceptive patches, and oral contraceptives (including emergency contraceptive pills). All FDA-approved contraceptive drugs, devices, and products available over the counter (OTC) are covered when prescribed by VHP contracted providers and filled at a VHP contracted pharmacy.
Dental Anesthesia	✓	✓	
Diabetes Education, Management, & Treatment	✓	✓	Diabetes education and management are covered. For diabetes medication treatment, refer to VHP's preferred medication formulary on VHP's website. **https://www.valleyhealthplan.org/sites/m/pn/Pharm/Pages/Pharmacy.aspx**
Dialysis	✓	✓	
Durable Medical Equipment (DME)	✓	✓	

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Valley Health Plan

CH 4: Member Benefits, Exclusions, & Limitations

	Covered		Not Covered
✓		✗	

Benefits	CC & IFP	EG	Details and Limitations
Emergency Room Services	✓	✓	Emergency room services for non-emergency care are excluded from coverage.
Emergency Transportation/ Ambulance	✓	✓	Ambulances are covered for emergencies. For non-emergencies, transportation is a covered benefit with prior authorization from VHP.
Hearing Aids	✗	✓	**COCA/IFP Members – Not Covered** Only covers internally-implanted devices as described in the "Prosthetic and Orthotic Devices section of the member's EOC. **Employer Group Members – Covered** Hearing Aid benefits are limited to once every 36 months and up to a coverage maximum of $1,000.00, regardless of the number of hearing aids or devices prescribed under the member's benefit plan.
Home Health Care Services	✓	✓	**Limitations & Exclusions include:** Meals, childcare, in-home day care, & housekeeping services.
Hospice Services	✓	✓	Coverage is limited to members who have been given a prognosis of 12 months or less to live. Coverage is limited to a maximum of 366 days of hospice care, including five (5) consecutive days of inpatient respite care.
Infertility Treatment	✗	✓	**Employer Group Members – Covered** Covered when medically necessary. Please refer to the EOC section "Family Planning Services, Infertility Diagnosis and Treatment" for detailed benefits, exclusions, and limitations. Covered when medically necessary. Please refer to the information under the "Family Planning Services" section of the EOC for detailed benefits, exclusions and limitations.

CH 4: Member Benefits, Exclusions, & Limitations

Valley Health Plan

Benefits	CC & IFP	EG	Details and Limitations
	✔ Covered	✖ Not Covered	
Infusion Therapy	✔	✔	Refer to VHP's preferred medication formulary: **https://www.valleyhealthplan.org/sites/m/pn/Pharm/Pages/Pharmacy.aspx**
Inpatient Hospital Services (e.g., Hospital Stay)	✔	✔	Services include: • Semi-private room and board, intensive care, operating room, inpatient drugs, X-rays, lab tests, supplies, acute rehabilitation, dialysis, and medically necessary blood, blood derivatives, and transfusions (blood bank); • Ancillary services, such as laboratory, pathology, radiology, radiation therapy, cathode ray scanning, inhalation and respiratory therapy, physical therapy, occupational therapy, and speech therapy; • Diagnostic and therapeutic services; • Discharge planning services and the coordination and planning of such continuing care; • Surgical and anesthetic supplies furnished by the hospital as a regular service; • Physician and surgeon care; and • Inpatient skilled nursing care.
Laboratory Outpatient & Professional Services	✔	✔	Routine laboratory testing as part of an approved office visit do not require authorization. VHP follows the guidelines provided by the U.S. Preventive Services Task Force Grade A and B preventive services: **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations**
Long-Term/Custodial Nursing Home Care	✖	✖	

Valley Health Plan

CH 4: Member Benefits, Exclusions, & Limitations

	✓ Covered	❌ Not Covered	

Benefits	**CC & IFP**	**EG**	**Details and Limitations**
Maternity Care	✓	✓	Coverage includes prenatal and postnatal care with in-network providers. The mother and newborn child are entitled to at least 48 hours of inpatient hospital care following a normal vaginal delivery or 96 hours following a delivery by cesarean section. An earlier discharge may be arranged when the decision is made jointly by the member and attending physician. Ipatient hospital services for the baby after the member has been discharged are considered a separate hospital admission. Enrollment of the newborn is required for continued coverage. To ensure continued coverage, members must enroll their newly eligible dependent(s) within 31 days after birth. If members fail to do so, they must wait until their employer's next Open Enrollment Period to enroll the baby. Amniocentesis, ultrasounds, or any other procedure performed solely for the purpose of sex determination are excluded.
Mastectomies & Lymph Node Dissections	✓	✓	Coverage includes medically necessary mastectomies and lymph node dissections. This includes hospitalization, office visits, and physician and surgeon costs. Covered services include prosthetic devices and reconstructive surgery, including devices or surgery to restore and achieve symmetry for the patient incident to the mastectomy.
Mental/Behavioral Health Inpatient Services	✓	✓	Refer to Chapter 19, "Behavioral Health Services."
Mental/Behavioral Health Outpatient Services	✓	✓	Refer to Chapter 19, "Behavioral Health Services."
Nutritional Counseling	❌	❌	Except for health education classes, nutritional counseling is not a covered benefit.
Outpatient Facility (e.g., Ambulatory Surgery Center)	✓	✓	
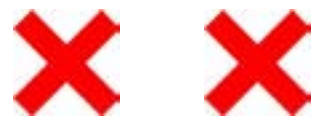
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CH 4: Member Benefits, Exclusions, & Limitations

	Covered		Not Covered

Benefits	CC & IFP	EG	Details and Limitations
Outpatient Surgery Physician/Surgical Services	✓	✓	
Phenylketonuria (PKU)	✓	✓	
Prescription Drugs: Generic/Preferred Brand/ Non-Preferred Brand/ Specialty	✓	✓	Prescriptions filled at an out-of-network pharmacy are covered if related to care for a medical emergency or urgently needed care. If the requested prescription is not listed on the formulary, **a prior authorization is required**. Refer to VHP's preferred medication formulary for drug benefit coverage: **https://www.valleyhealthplan.org/sites/m/pn/Pharm/ Pages/Pharmacy.aspx**
Previously Prescribed Prescription Drugs	✓	✓	Refer to **Chapter 16, "Pharmacy Services."**
Preventive Care/Screening/ Immunization	✓	✓	Preventive and immunization services are covered services in accordance with the Centers for Disease Control (CDC), Preventive Services Task Force A and B guidelines. Refer to the U.S. Preventive Services Task Force for a complete list of preventive services: **https://www.uspreventiveservicestaskforce.org/ uspstf/recommendation-topics/uspstf-a-and-b- recommendations** Travel health immunization consultations are not a covered benefit.

	Covered		Not Covered
✓		✗	

Benefits	CC & IFP	EG	Details and Limitations
Preventive Services	✓	✓	Services for children and adults include but are not limited to preventive health assessment visits, well-child screenings and immunizations. Well-child preventive exams are covered for members through age 23 months. Pediatric/well-child care, including periodic office visits, diagnostic laboratory services, immunizations, pediatric asthma services, and the testing and treatment of phenylketonuria (PKU) may be covered. The age, health status, and medical needs of the child determine the frequency of these examinations.
Private-Duty Nursing	✗	✗	
Reconstructive Surgery	✓	✓	Reconstructive surgery is covered to reconstruct a breast after it is fully or partially removed. Reconstructive surgery is also a covered benefit if the provider determines it is medically necessary improve the function or create a normal appearance of an abnormal structure.
Rehabilitative Occupational, Speech, & Physical Therapy	✓	✓	Vocational rehabilitation is excluded.
Routine Foot Care	✓	✓	Excludes the trimming of corns, calluses, and nails, unless medically necessary.
Routine Vision Services	✓	✓	For Covered California and IFP: Prior authorization for low vision aids and low vision exams. Eyeglasses and contact lenses **are covered for children who are under the age of 19 only.** **For Employer Group:** Eye examinations, eyeglass lenses, frames and contact lenses and other routine services are covered through Vision Service Plan (VSP).
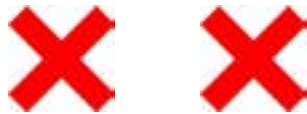
Valley Health Plan

CH 4: Member Benefits, Exclusions, & Limitations

	Covered		Not Covered

Benefits	CC & IFP	EG	Details and Limitations
Skilled Nursing Facility (SNF)	✓	✓	**Covered CA and IFP members:** Coverage is limited to 100 days per calendar year of prescribed and authorized skilled nursing services in a VHP contracted SNF or a skilled nursing bed in a VHP contracted hospital. **Employer Group members (Classic and Preferred):** Coverage is limited to a maximum of 100 days per calendar year.
Specialist Visit	✓	✓	**A referral from the member's PCP is required.** Failure to receive prior authorization approval by VHP will result in the denial of the unapproved specialty visit and all services rendered in conjunction with that visit.
Substance Abuse Disorder Inpatient Services	✓	✓	Refer to Chapter 19, "Behavioral Health Services."
Substance Abuse Disorder Outpatient Services	✓	✓	Refer to Chapter 19, "Behavioral Health Services."
Transplant	✓	✓	**Limitations & Exclusions include:** Services for organ, tissue and bone marrow transplant treatment are subject to the limitations and exclusions as outlined under the member's EOC. Services must meet the medically necessary criteria and be approved by VHP. Organ donor searches and recipient or donor transportation costs to the transplantation center are excluded from coverage under the benefit plan.
Transportation	✓	✓	Emergency medical transportation: Covered. Non-emergent medical transportation: Covered only for medically necessary inter-facility transportation.

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Valley Health Plan

CH 4: Member Benefits, Exclusions, & Limitations

	Covered		Not Covered
✓		✗	

Benefits	CC & IFP	EG	Details and Limitations
Treatment for Temporomandibular Joint (TMJ) Disorders	✓	✓	Services include the evaluation and treatment of medically necessary TMJ dysfunction, including the provision of prescribed intra-oral appliances. **Limitations & Exclusions includes:** A lifetime limitation of $800.00 applies to the cost of any intra-oral positioning device and related services. Routine dental services and dental treatment are excluded services.
Urgent Care Centers or Facilities	✓	✓	
X-Ray & Diagnostic Imaging (CT/PET Scans, MRIs)	✓	✓	Routine x-rays and diagnostic imaging performed as part of an approved office visit do not require an authorization.
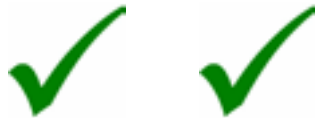
Network Development and Maintenance

VHP facilitates the provision of covered services as specified by Department of Managed Health Care (DMHC). Our approach to developing and managing the provider network begins with a thorough analysis and evaluation of the DMHC network adequacy requirements. VHP maintains a network of qualified providers in sufficient numbers, geographic distribution, and specialty coverage to meet the medical needs of its members. This includes consideration of the needs of adults and children, as well as members' travel requirements, so that VHP's network complies with DMHC access and availability requirements.

VHP offers a network of PCPs to provide each member with access to primary care within the required travel distance standards. Providers who may serve as PCPs include internists, pediatricians, obstetrician/gynecologists, family, and general practitioners.

In the event VHP is unable to provide medically necessary services required for a member, VHP will facilitate timely and adequate coverage of these services through an out-of-network provider, and coordinate the authorization and payment in these circumstances, until such time that a network provider is contracted.

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For assistance in making a referral to a non-contracted specialist or subspecialist for a VHP member, contact VHP's Utilization Management team at **1.408.885.4647** (For TTY, contact California Relay by dialing **711** and provide the number **1.800.735.2929**) and VHP will identify a provider for the necessary referral.

Tertiary Care

VHP offers a network of tertiary care providers inclusive of level one and level two trauma centers, neonatal intensive care units, perinatology services, comprehensive cancer services, comprehensive cardiac services, and pediatric subspecialists available 24 hours per day. In the event VHP is unable to provide the necessary tertiary care services required, VHP will facilitate timely and adequate coverage of these services through an out-of-network provider, until a network provider is contracted, and coordinate the authorization and payment in these circumstances.

VHP has contracted with tertiary and quaternary care hospitals which may only be utilized when services are not otherwise available in the primary network chosen by the member. For further information about referrals to these facilities or for assistance in making a referral to a non-contracted tertiary and quaternary care hospital for a VHP member, contact VHP's Utilization Management team at **1.408.885.4647** (for TTY, contact California Relay by dialing **711** and provide the number **1.800.735.2929**) and VHP will identify a provider for the necessary referral.

CH 4: Member Benefits, Exclusions, & Limitations

CH 5:
Member Rights & Responsibilities

This Chapter Includes:

1. **Member Rights**

2. **Member Responsibilities**

	Alert
!	Alert draws attention to critical information that has changed this year.
📞	**Contact** Contact information on who to contact for assistance.
VHP	**Book Table of Contents** Click the purple VHP circle logo, located at the bottom left corner, to return to the main TOC.

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As a VHP provider, you should be aware of VHP's Member Rights and Responsibilities statement. This statement is published each year in the member's Evidence of Coverage (EOC). It is also available on the VHP website at **https://www.valleyhealthplan.org/members/member-materials/member-rights-and-responsibilities** or by contacting the Member Services Department at **1.888.421.8444**.

Member Rights

A member has the right to:

1. Exercise these rights without regard to race, disability, sex, religion, age, color, sexual orientation, creed, family history, marital status, veteran status, national origin, handicap, or condition, without regard to your cultural, economic, or educational background, or source(s) of payment for your care;

2. Be treated with respect and recognition regarding your dignity and your right to privacy;

3. Expect health care providers (doctors, medical professionals, and their staff) to be sensitive to your needs;

4. Be provided with information about VHP, its services, VHP's contracted providers, member rights and responsibilities;

5. Know the name of the Primary Care Provider (PCP) who has primary responsibility for coordinating your health care and the names and professional relationships of other VHP providers you see;

6. Actively participate in your own health care, which, to the extent permitted by law, includes the right to receive information so that you can accept or refuse recommended treatment;

7. Receive as much information about any proposed treatment or procedure as you may need to give informed consent or to refuse this course of treatment or procedure. Except for Emergency Services this information will include a description of the procedure or treatment, the medically significant risks involved, alternative courses of action and the risks involved in each, in addition to the name of the VHP provider who will carry out the treatment or procedure;

8. Full consideration of privacy concerning your course of treatment. Case discussions, consultations, examinations, and treatments are confidential and should be conducted discreetly. You have the right to know the reason should any person be present or involved during these procedures or treatments;

9. Confidential treatment of information in compliance with state and federal law including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (including all communications and medical records) pertaining to your care. Except to fulfill state and federal requirements (including review programs to achieve quality and cost-effective medical care), such information will not be disclosed without first obtaining written permission from you or your authorized representative;

10. Receive complete information about your medical condition, any proposed course of treatment, and your prospects for recovery in terms that you can understand;

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11. Give informed consent unless medically unattainable, before the start of any procedure or treatment;

12. Refuse health care services to the extent permitted by law and to be informed of the medical consequences of that refusal, unless medically unattainable;

13. Readily accessible and ready referral to medically necessary covered services;

14. A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage;

15. A second medical opinion, when medically appropriate, from a provider within the member's chosen primary network unless the requisite specialty is not available;

16. Be able to schedule appointments in a timely manner;

17. Reasonable continuity of care and advance knowledge of the time and location of your appointment(s);

18. Reasonable responses to any reasonable requests for covered services;

19. Have all lab reports, x-rays, specialist's reports, and other clinical documents completed and placed in your medical record as promptly as possible so that your PCP) can make informed decisions about your treatment;

20. Change your PCP;

21. Request an expedited change of a provider due to medical necessity;

22. Review your medical records, unless medically inadvisable;

23. Be informed of any charges (member cost sharing amounts) associated with covered services;

24. Be advised if a VHP provider proposes to engage in or perform care or treatment involving experimental medical procedures, and the right to refuse to participate in such procedures;

25. Leave a VHP contracted facility or hospital, even against the medical advice of a VHP provider;

26. Be informed of continuing health care requirements following your discharge from VHP contracted facilities or hospitals;

27. Be informed of, and if necessary, given assistance in making a medical Advance Directive;

28. Have rights extended to any person who legally may make decisions regarding medical care on your behalf;

29. Know when providers are no longer under a contractual arrangement with VHP;

30. Examine and receive an explanation of any bill(s) for non-covered services, regardless of the source(s) of payment;

31. Voice complaints or appeals about VHP or the care received;

32. File a grievance without discrimination through VHP or appropriate state or federal agencies;

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CH 5: Member Rights & Responsibilities

33. Know the rules and policies that apply to your conduct as a member;

34. Make recommendations regarding VHP's member rights and responsibilities policy; and

35. Participate with providers in making decisions about your health.

Member Responsibilities

A member has the responsibility to:

1. Provide complete and accurate information (to the extent possible) that VHP and its providers need to provide care. Inform provider about any health issues, medications, and allergies. This information should also include living will, medical power of attorney, and/or any other directive that could affect care;

2. Follow plans and instructions for care that you have agreed to with your provider;

3. Behave in a manner that does not interfere with your provider's ability to render care and services;

4. Safeguard the confidentiality of your own personal health care as well as that of other members;

5. Accept fiscal responsibility associated with non-covered services. Covered services are available only through providers in your chosen primary network (unless such care is rendered as Emergency Services or has been authorized by VHP);

6. Cooperate with VHP or VHP's designee for third-party recovery efforts and coordination of benefits (COB) activities;

7. Participate in your health care by scheduling and keeping appointments with VHP providers. If you cannot keep your appointment, call in advance to cancel and reschedule;

8. Report any changes in your name, address, email address, telephone number(s), or your family's status to your employer's benefits manager, Covered California, and a VHP Member Services Representative **1.888.421.8444**; and

9. Understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.

CH 5: Member Rights & Responsibilities

Valley Health Plan

CH 6:
Cultural, Linguistics, & Disability Access Requirements & Services

This Chapter Includes:

	Alert Alert draws attention to critical information that has changed this year.
	Contact Contact information on who to contact for assistance.
	Book Table of Contents Click the purple VHP circle logo, located at the bottom left corner, to return to the main TOC.

Overview

VHP is committed to providing equal access to quality health care services in a manner responsive to diverse cultural health beliefs and practices, preferred languages, disability access requirements, health literacy, and other needs. VHP provides these services in accordance with the U.S. Office of Minority Health Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), and all relevant federal, state, and local requirements. VHP accomplishes this commitment in partnership with providers through the following:

- Identifying the cultural, communication and disability access needs of members;

- Providing cultural, linguistic, and disability access services in a timely manner at no cost to members; and

- Educating members so they fully understand the health care services they receive, can participate in their own care, and make informed decisions.

Summary of VHP's Language Assistance Plan

VHP is committed to identifying and addressing disparities. VHP's Language Assistance Program (LAP) specifies the roles and responsibilities of VHP and its contracted providers in supporting the reduction and elimination of barriers based on English language proficiency. It is the policy of VHP to enhance and implement strategic plans that improve access and eliminate disparities in the quality of care and access for individuals with Limited English Proficiency (LEP) or non-English speaking individuals and to comply with Senate Bill 853, LAP regulations.

VHP's Threshold Languages

1. English
2. Spanish
3. Vietnamese

Identifying Limited English Proficiency Members

While caring for VHP members, providers may identify a patient with limited English proficiency. Providers must offer language assistance resources to identified LEP members.

Providers may identify LEP members when they:

- Self-identify as LEP by requesting language assistance;

- Bring a family member or a friend to interpret;

- Have trouble communicating in English or the provider has a difficult time understanding what is communicated;

- Respond with simple "yes" or "no" answers or give inappropriate or inconsistent answers to questions; or

- Are quiet or do not respond to questions.

Valley Health Plan

CH 6: Cultural, Linguistics, & Disability Access Requirements & Services

Demographic Profile

VHP will disclose member demographic profile data (including identification of VHP's threshold languages) to contracting providers (including physicians' offices, hospitals, laboratories, radiology centers, physical therapy offices, and pharmacies services) upon request.

Providing Interpretation Services

VHP provides the following interpretation resources to contracted providers to assist members:

- Providers should contact VHP Language Services by dialing **1.844.670.6820** or **1.850.633.4047** to gain access to interpretation resources. For TTY, contact the California Relay by dialing **711** and provide the following phone number: **1.800.735.2929**.

- Upon reaching Language Services, a caller should be prepared to identify themselves as a VHP network provider, inform Language Services they are calling on behalf of a VHP member, and identify the language requiring interpretation.

- For in-person interpretations, a request should be submitted to Language Services 72 hours in advance of when the in-person interpretation is needed. To schedule an in-person interpretation, call **1.844.670.6820**.

- The requestor will need to provide Language Services with the name of the provider, provider's address, the member's name and VHP ID number, the language needed, and the appointment date, time, and location.

- Providers must arrange for, or cooperate with the following VHP provisions:

- Interpretation services, in multiple languages (including American Sign Language) are offered at all key points of contact for members accessing routine, urgent, and emergency health care services;

- The delivery of interpretation services includes, but is not limited to trained and competent face-to-face interpreters, signers, or bilingual providers and provider staff, telephone or telecommunications relay language services, or any electronic options VHP and the provider choose to utilize, in a manner that is appropriate for the situation in which language assistance is needed;

- Offer fully translated, written materials in the designated threshold languages required by VHP;

- Offer oral interpretation for a non-English language upon request; and

- Make available auxiliary aids and services, and modifications of policies, practices, and procedures for members with disabilities within a reasonable time-frame appropriate for the situation.

Providers must inform and facilitate access to these no-cost services to VHP members. In addition, providers must document the offer or provision of the services in the member's medical record, including any instance in which the member declines the services. Providers must also provide any information necessary to assess compliance; require bilingual providers and/or office staff to complete and sign capability disclosure forms; and provide monthly updates on any changes in disability access and/or the language capabilities of providers or staff for the VHP Provider Directory. See Chapter 2 "Resources for Providers" and Chapter 9, "Credentialing and Recredentialing."

If a member insists upon using a friend, family member, or minor to translate for them during a provider visit, the provider is required to document in the member's medical record the refusal of qualitied interpreter services and the preference of the member to use a family member, friend or minor as an interpreter. It is important to also document in the member's medical record the name and contact information of any interpreter whose services were used for a health care visit.

In certain situations, such as in an emergency, a minor may be the only available, knowledgeable interpreter. If this situation occurs, verify the following conditions before the use of a minor as an interpreter:

- The minor can demonstrate an ability to understand and interpret complex medical information that is relevant to the current situation.
- The member is fully informed in their preferred language that a qualified interpreter is available to them and can be provided to interpret at no charge.

Document in the member's medical record that these conditions were assessed and verified.

Tips for Working with Interpreters

- Speak at an even pace in relatively short segments or sentences.
- Pause often to allow the interpreter to translate.
- Ask one question at a time.
- Acknowledge the interpreter as a professional.

For hearing impaired members, contact California Relay Services by dialing **711** or **1.800.735.2929**. VHP will assist hearing impaired members to access language services.

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CH 6: Cultural, Linguistics, & Disability Access Requirements & Services

Vital Documents

Vital documents are generally those documents that describe benefits, exclusions, limitations, and terminations of the member's services or benefits. VHP identifies vital documents based on regulatory requirements and translates these documents into VHP's threshold languages. Vital documents are classified into two categories – standard and non-standard.

Standard Vital Documents

1. Applications and consent forms;

2. Notices of the right to file a grievance or appeal; and

3. Notice of language assistance at no cost.

Non-Standard Vital Documents

1. Letters containing important information regarding eligibility and participation criteria; and

2. Notices pertaining to the denial, reduction, modification, or termination of services and benefits.

Request for Translation

Providers should forward the member's request for translation of standard and non-standard documents to VHP's Member Service Department using the following email: **Memberservices@vhp.sccgov.org** within one day if it is urgent or within two days if it is not urgent.

> **Note:** If appropriate based on the language proficiency of a VHP provider, the provider can also translate the vital document(s) to the member.

VHP will make the determination if a document meets the criteria of a non-standard vital document, in which case VHP will have the document translated, and will send the translated document to the requesting provider. Members requiring additional help to read any document should be instructed to call the VHP Member Services Department at **1.888.421.8444** for additional assistance.

> Providers are required to submit to VHP all relevant documentation, including provider language capability disclosure forms and attestations, when providers utilize themselves or staff as translators. The VHP Language Capability Attestation (Disclosure) Form is available on the VHP website at **https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/Language-Attestation-Form.pdf** and a copy is included in the **Appendix**.

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CH 6: Cultural, Linguistics, & Disability Access Requirements & Services

Please email, fax, or mail the completed form to:

> **Valley Health Plan**
> **Attention: Language Assistance Program**
> **2480 N. First Street, Suite #160**
> **San Jose, CA 95131**
> Email: **memberservices@vhp.sccgov.org**
> Fax: **1.408.885.4425**

Training and Education

Providers are expected to ensure that all employed or contracted providers and their staff receive appropriate education and training regarding VHP's LAP through a formal process. Regulations require that any provider who utilizes bilingual office staff as translators must ensure that the translator demonstrates proficiency at the minimum standards set forth below:

- A demonstrated and properly documented proficiency in both English and the other language.

- A fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems.

- Education and training in interpreting ethics, conduct, and confidentiality.

Monitoring LAP Compliance

VHP's LAP annual compliance audit includes:

1. Monitoring VHP's internal organization, vendors, and contracted providers for compliance with regulatory standards for the LAP, including the availability, quality, and utilization of language assistance services;

2. Tracking grievances and complaints related to its LAP;

3. Tracking language attestations and/or language capability disclosure forms; and

4. Documenting actions taken to correct problems.

Inclusion and Culturally Responsive Health Care

VHP considers inclusion an important part of the delivery of care. Therefore, VHP expects all of its network providers to treat members equally regardless of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, program membership or physical or behavioral disabilities except where medically required.

VHP acknowledges the impact of culture, diversity, and language preference on providing culturally responsive health care. VHP encourages providers to recognize and address a LEP member's needs alongside VHP's efforts to assist LEP members. It is the goal of VHP to recognize and address concerns when a communication breakdown occurs, whether due to an existing language barrier, or differences in cultural expectations such as health beliefs and practices that may affect member engagement or adherence to treatment plans. It is the policy of VHP to continue to enhance and implement policies and initiatives that improve access and eliminate disparities for individuals with limited English proficiency and non-English speaking individuals and to comply with Senate Bill (SB) 835 LAP regulations.

Valley Health Plan

CH 6: Cultural, Linguistics, & Disability Access Requirements & Services

CH 7:
Health Education Program

This Chapter Includes:

(!)	**Alert** Alert draws attention to critical information that has changed this year.
📞	**Contact** Contact information on who to contact for assistance.
VHP	**Book Table of Contents** Click the purple VHP circle logo, located at the bottom left corner, to return to the main TOC.

Health Education

At VHP we believe in "Better health for all." VHP offers a variety of resources to help members learn how to live well and be healthy. Topics include asthma, diabetes, weight management, pregnancy, smoking cessation, and many others.

Providers can refer members to health education classes or materials by contacting VHP Health Education at **1.408.885.3490** or e-mail: **healtheducation@vhp.sccgov.org**. The following information will be required for a referral for health education:

- Member information (name, date of birth and VHP ID number)
- Provider contact information (telephone and fax)
- Preferred language
- The type of class or material requested for the member or title of the class (see below for class information)
- Any comments specific to the member's needs

Youth Diabetes Summer Camp

The YMCA offers one-week summer camp sessions for youth who are at risk of developing type II diabetes. The program focuses on nutrition education and practicing a healthy eating lifestyle. The program is free for VHP members ages 6-16.

Youth Asthma Camp

A free one-week asthma camp is offered for children ages 6-12 and their families. The camp addresses asthma problems through asthma self-management and offers unique opportunities for children to socialize with their peers who have the same chronic illness. The camp is organized with the goal of providing an entertaining and educational summer camp experience. In addition to asthma self-management, campers are provided with opportunities to try new activities at their own (often reduced) level of participation. Camp fellowships and informal social interactions in a variety of settings (sports, picnic, nature study, hiking, boating, fishing, swimming, crafting, etc.) are offered as part of the program.

Diabetes Prevention Program

VHP partners with the YMCA to offer members a free Adult Diabetes Prevention Program, which includes a four-month YMCA membership. The YMCA's Adult Diabetes Prevention Program helps members learn and adopt healthy eating and physical activity habits with the goal of reducing the risk of developing type II diabetes. Members will receive support and encouragement from both a trained lifestyle coach and fellow classmates as they develop a plan for improving and maintaining their overall well-being. In addition, distance learning options have been added beginning in October 2020.

Nutrition

VHP offers free nutrition classes to its members through the YMCA. The one-hour classes are hosted and conducted by a Registered Dietician and provided quarterly every year. Topics vary and include "Tips for Healthy Weight Loss," "Tips for Traveling," "Eating Out in a Restaurant," "Smart Snacking," "The Amazing Benefit of Omega 3," "Holiday Survival Guide," and "How to Cook with Whole Grain."

Fitness & Wellness Classes

VHP offers group fitness classes free of charge to members. Classes vary and include Pilates, Yoga, Zumba, and Sports Conditioning. All instructors are certified and meet industry standards. While classes were offered throughout the County of Santa Clara (County), in-person classes have been discontinued due to COVID-19. Beginning in Fall 2020, VHP offers virtual fitness classes free of charge to members. The Zoom platform is utilized, providing flexibility and easy access to the fitness classes.

WW (Formerly Weight Watchers)

VHP is committed to helping members reach their wellness goals, whether to achieve a healthy weight, learn better eating habits, move more, or develop a more positive mindset. VHP offers WW (Weight Watchers reimagined) to members. Members can join the program through several membership options. WW has moved from in-person workshop meetings to a virtual platform due to COVID-19. VHP continues to subsidize 50 percent of the cost for its members.

Member Outreach

In collaboration with VHP's Case Management and Member Services Departments, Health Education conducts outreach to members through one-on-one phone calls. These calls serve as an opportunity to provide education to members on prevention campaigns as well as promote a vital and free of charge online resource, MDLive (see "Chapter 19, Behavioral Health Services").

Collaboration with other County of Santa Clara Departments

Health Education collaborates with various County departments to carry out initiatives led by the Board of Supervisors, such as:

- County Diabetes Prevention Initiative (DPI) to ensure that residents with pre-diabetes are identified and connected to prevention education and active living resources;

- County Employee Wellness Division to improve the health and well-being of the workforce through campaigns such as "#CampWell2020" and "Know Your Health, Keep Your Health"; and

- County Tobacco-Free Communities (TFC) to reduce illness and premature death attributed to the use of tobacco products.

CH 7: Health Education Program

Health Education Materials

VHP has contracted with Krames Staywell to make health education materials available to its members. Providers may request materials free of charge. These materials have been reviewed for cultural and linguistic standards and are available in English, Spanish and Vietnamese.

Topics include:

- Allergies
- Asthma
- Behavioral Health
- Breast Health
- Cancer
- Children's Health
- Colon Cancer
- Diabetes
- Eating Healthy
- Exercise for Busy People
- Healthy Aging
- High Blood Pressure
- Men's Health
- Pain Management
- Self-Care for Adults
- Smoking Cessation
- Sexually Transmitted Diseases
- Stress Management
- Weight Management
- Women's Health

To request an order form, packet of sample materials or materials on a specific topic, contact the Health Education Department at **1.408.885.3490** or e-mail: **healtheducation@vhp.sccgov.org**.

Valley Health Plan

CH 7: Health Education Program

CH 8:
Facility Site, Physical Accessibility, & Medical Record Review

This Chapter Includes:

	Alert
!	Alert draws attention to critical information that has changed this year.
☎	**Contact** Contact information on who to contact for assistance.
VHP	**Book Table of Contents** Click the purple VHP circle logo, located at the bottom left corner, to return to the main TOC.

Facility Site Review Process

The facility site review is a comprehensive evaluation of a provider's facility, administration, and medical records maintenance to ensure that the facility meets certain safety, accessibility, and security standards pursuant to state and federal regulations. The review of PCP sites is required for all VHP contracted PCPs and VHP reserves the rights to adopt additional requirements.

The overall facility site review process has three components:

1. Facility site review (FSR);

2. Physical accessibility review survey; and

3. Medical records review (MRR).

(!) Providers must have a site review conducted prior to being credentialed by VHP. Thereafter, providers will be included in a sampling audit, which is based on the three-year FSR requirement. All providers must make their offices available for a physical accessibly review, FSR, and/or MRR audit. Provider participation in reviews and audits is mandatory. VHP will collaboratively work with providers to coordinate visits and minimize the impact of reviews/audits on provider office operations as well as to ensure that VHP meets regulatory and contractual requirements.

Conducting the Site Review

A VHP Representative from Provider Relations or Quality Management departments will contact providers to schedule an appointment date and time for a site review and provide a confirmation letter with an explanation of the review process and required documentation.

During an in-person site review, a VHP reviewer will:

- Lead the pre-review conference with the provider or office manager to provide an overview of the process and answer any questions;

- Conduct the site review; and

- Document any deficiencies.

Following the site review, the VHP reviewer will confer with the provider or office manager to:

- Discuss the results of the review and explain any required corrective actions;

- Provide a results letter and corrective action plan to the office manager or provider, when applicable;

- Educate the provider or office staff about the standards and policies; and

- Schedule a follow-up review for any corrective actions identified.

Valley Health Plan

CH 8: Facility Site, Physical Accessibility & Medical Record Review

PCP and primary care clinic site review results must be 90% or greater with all critical elements "met" to pass. Scores below 90% or with any critical element "not met" will require a corrective action plan (CAP). A written CAP from the PCP or primary care clinic is required within 30 calendar days of the date on the results letter received from VHP. The CAP should be sent to the VHP reviewers who conducted the facility site review.

Site Review Tools

See the **Appendix** for Site Review Tools Examples

Facility Site Review Tool/Guidelines

If you would like to review the facility site review survey tool which includes the physical accessible review component, scoring and guidelines, please use the following links:

- **FSR Tool**
  https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/Behavioral-Health-Office-Audit-Tool.pdf
- **Medical Clinic/Office Tool**
  https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/Medical-Clinic-Office-Audit-Tool.pdf

Medical Record Review Tool/Guidelines

If you would like to see how the medical record review will be audited, scored and the guidelines, use the following link: **https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/documents/P-MedicalRecordAuditTool-EN-041822-QM.pdf**

Medical Record Requirements and Review

VHP reviews medical records for format, legal protocols, and documented evidence of the provision of preventive care, care coordination, and continuity of care services. Incomplete records or lack of documentation implies that there was a gap or failure to provide care. The medical record provides legal proof that the member received care and therefore must reflect all aspects of a member's care and ancillary services, including but not limited to the following:

Medical Record Regulatory Requirements

- A record shall be permanent, either electronic, typewritten or legibly written in ink and shall be kept for each unique VHP member accepted for treatment.
- All medical records of discharged VHP members shall be completed within 30 days following termination of each episode of treatment and such records shall be kept for a minimum of seven

years, except for minors whose records shall be kept at least until one year after the minor has reached the age of 18, but in no case less than seven years. This includes all records, results of diagnostics including exposed x-ray film.

- All required records, either originals or accurate reproductions thereof, shall be maintained in such form as to be in English, legible and readily available upon the request of the provider, the primary care clinic or any authorized officer, agent or employee of either, or any person authorized by law to make such request.

- Information contained in the medical records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state, and local laws.

- The medical record shall be the property of the provider and shall be maintained for the benefit of the member, medical care team and primary care clinic and shall not be removed from the VHP provider's office or primary care clinic, except for storage purposes after termination of services.

- Providers must delegate an individual to be responsible for the securing and maintaining medical records at each site.

- If a provider ceases operation, arrangements shall be made for the safe preservation of VHP's members' medical records. The provider who ceases operation must notify VHP at least 48 hours before cessation of operation by contacting Provider Relations at: **providerrelations@vhp.sccgov.org**, or to VHP in writing at:

> **Valley Health Plan**
> **Attn: Provider Relations**
> **2480 N. First Street, Suite 160**
> **San Jose, CA 95131**

- If the ownership of a provider's practice changes, both the licensee and the applicant for the new license shall, prior to the change of ownership, provide VHP with written documentation. The written documentation can be emailed to: **providerrelations@vhp.sccgov.org** or mailed to Valley Health Plan 2480 N. First Street, Suite 160 San Jose, CA 95131. The written documentation shall state the following:

  o The new licensee shall have custody of VHP's members' medical records and these records shall be available to the former licensee, the new licensee, and other authorized persons; or

  o The current licensee has made other arrangements for the safe preservation and the location of the members' medical records, and that they are available to both the new and former licensees and other authorized persons.

Clinical Requirements for Medical Records

- All medical record entries shall be dated and be authenticated with the name, professional title,

and classification of the person making the entry.

- Members' medical records shall be stored to ensure protection against loss, destruction, or unauthorized use.

- Members' medical records shall be filed in an easily accessible manner in the PCP's office or primary care clinic.

- The medical record must reflect all aspects of the member's care, including ancillary services, and at a minimum include the following:

    o Member identification on each page; personal/biographical data in the record;

    o The VHP member's preferred language (if other than English) and disability access needs prominently noted in the record, as well as the request or refusal of language/interpretation/disability access services;

    o For member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, assessment and the plan for diagnosis and treatment (SOAP notes);

    o The record shall contain a problem list, a complete record of immunizations, medical maintenance and preventive services rendered;

    o Allergies and adverse reactions must be prominently noted in the record;

    o All informed consent documentation, including for human sterilization consent procedures;

    o All reports of emergency care provided (directly by the provider or through an emergency room) and the discharge summaries for all hospital admissions;

    o Consultations, referrals, specialist consultations, pathology, and laboratory reports;

    o Any abnormal results shall have an explicit notation in the record; and

    o For medical records of adults, documentation of whether the member has been informed of their rights to make decisions concerning medical care; to have an Advance Directive; and whether an Advance Directive or a Durable Power of Attorney for Medical Care has been executed.

All clinical requirements for medical records are set forth in VHP's Medical Records policy, which is available by contacting Provider Relations at: providerrelations@vhp.sccgov.org, or to VHP in writing at:

> **Valley Health Plan**
> **Attn: Provider Relations**
> **2480 N. First Street, Suite 160**
> **San Jose, CA 95131**

The clinical medical records requirements policy is also provided in the provider orientation package.

Medical Records Release

All VHP member medical records shall be confidential and shall not be released without the written authorization of the member or a member's legal guardian or authorized representative. When the release of medical records is appropriate, the extent of that release shall be based upon medical necessity or on a need to know basis. Providers and community mental health programs must obtain written consent from the member to release information to coordinate care regarding primary care and mental health services or substance use disorder services or both.

Medical Records Transfer for New Members

When a member changes their PCP or primary care clinic, upon request, his or her medical records or copies of medical records must be forwarded to the newly assigned PCP or primary care clinic within ten business days from receipt of request or prior to the next scheduled appointment to the new PCP, whichever is earlier.

All PCPs and primary care clinics are required to document in the VHP member's medical record attempts to obtain historical medical records for all newly assigned VHP members. If the member or member's guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous PCP or providers, then this should also be noted in the medical record.

Medical Record Reviews

VHP will conduct random medical record review audits as part of its Quality Assurance Program to monitor compliance with the medical record documentation standards and requirements. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services, also may be assessed during a medical record audit. VHP will provide written notice prior to conducting a medical record review.

MRR audit results must be 90% or greater to pass. Scores below 90% will require a CAP. A written CAP from the provider is required within 30 calendar days of the date the results letter is received from VHP. The CAP should be sent to the VHP reviewer who conducted the MRR audit

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**CH 8: Facility Site, Physical Accessibility
& Medical Record Review**

CH 9:
Credentialing & Recredentialing

This Chapter Includes:

	Alert
!	Alert draws attention to critical information that has changed this year.
📞	**Contact** Contact information on who to contact for assistance.
VHP	**Book Table of Contents** Click the purple VHP circle logo, located at the bottom left corner, to return to the main TOC.

Chapter 9 Includes: (Continued)

Alert
Alert draws attention to critical information that has changed this year.

Contact
Contact information on who to contact for assistance.

Credentialing Scope

The purpose of the credentialing and recredentialing process is to ensure that VHP maintains a high-quality health care delivery network. The credentialing and recredentialing processes support this goal by validating the professional competency and conduct of VHP's providers. This includes verifying licensure, board certification, and education, and identification of adverse actions, including malpractice or negligence claims, through the applicable state and federal agencies, facility site reviews (as described in Chapter 8, "Facility Site, Physical Accessibility & Medical Record Review"), and the National Practitioner Data Bank (NPDB). VHP providers must meet the criteria established by VHP, government regulations and the standards of accrediting bodies. VHP adheres to the credentialing and recredentialing standards promulgated by the National Committee for Quality Assurance (NCQA), as amended.

> **!** **Note:** VHP will deny payment of claims to providers that require credentialing for services rendered prior to the date the provider is approved for participation In VHP's network.

VHP conducts recredentialing at a minimum of every three years (36 months) to ensure the quality of its provider network and the currency of VHP's provider information.

In accordance with VHP and NCQA standards, VHP credentials the following providers, which include but is not limited to:

- Professional Providers:
  - Physicians (MD)
  - Dentists (DDS)
  - Oral surgeons (DMD)
  - Podiatrists (DPM)
  - Doctors of Osteopathy (DO)
  - Nurse Practitioners (NP)
  - Certified Nurse Practitioners (CNP)
  - Certified Registered Nurse Anesthetists (CRN)
  - Physician Assistants (PA)
  - Certified Nurse Midwifes (CNM)
  - Doctors of Chiropractic (DC)
  - Doctors of Optometry (OD)
  - Clinical Psychologists (PhD)
  - Behavioral Health providers, such as:
    - Marriage and Family Therapists (MFT)

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- ▪ Marriage, Family and Child Counselors (MFCC)
- ▪ Licensed Clinical Social Workers (LCSW)

- Ancillary providers:
  - o Acupuncturists
  - o Occupational Therapists
  - o Physical Therapists
  - o Speech Language Pathologists

- Facility and organizational providers:
  - o Free Standing Ambulatory Surgery Centers
  - o Behavioral Health Treatment Centers, such as:
    - ▪ Intensive Outpatient Programs
    - ▪ Partial Hospitalization Programs
    - ▪ Acute Psychiatric Hospitals
  - o Clinical Laboratories
  - o Diagnostic Imaging Centers
  - o Dialysis Centers
  - o Durable Medical Equipment (DME) Vendors
  - o Hospitals
  - o Home Health Agencies
  - o Hospice Agencies
  - o Infusion Centers
  - o Long-Term Acute Care Facilities
  - o Skilled Nursing Facilities (SNF)

Provider Credentialing Application Requirements

VHP utilizes the Council for Affordable Quality Healthcare® (CAQH) to obtain credentialing applications for professional providers. If you have not completed a CAQH application, you can locate the registration information and access the website through **https://proview.caqh.org/PR/Registration**. If you already have a CAQH credentialing application and number, please log into CAQH (**www.caqh.org**) to attest that your credentialing application is current and authorize VHP to access your information.

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If you require assistance, please feel free to contact the CAQH Provider Help Desk:
Chat: https://proview.caqh.org/PR
Chat hours: Monday – Friday: 8:30 AM to 6:30 PM (Eastern)
Phone: 1.888.599.1771
Phone hours: Monday – Thursday: 7:00 AM – 9:00 PM (Eastern); Friday: 7:00 AM – 7:00 PM (Eastern)

If you cannot access CAQH, an exception can be made using the California Participating Physician Application. VHP's Credentialing Department is responsible for initial and subsequent evaluation and verification of provider credentialing applications. The findings of the Credentialing Department are reviewed with the Chief Medical Officer (CMO) or designee and presented to the Credentialing Committee as recommendations. For VHP's Credentialing policy and procedures, contact VHP's Provider Credentialing Department at **1.888.421.8444** (for TTY, contact California Relay by dialing **711** or **1.800.735.2929**).

Minimum Qualifications for Initial Credentialing

A provider must meet the following minimum qualifications:

1. A completed, signed and dated uniform credentialing application.

2. A signed attestation as to the correctness and completeness of information included in the credentialing application. The attestation questionnaire includes:

   a. A minimum of five years' work history for new professional providers. Employment gaps of six months or longer are researched and an explanation is required to be documented in VHP's permanent credentialing file by the credentialing staff. Gaps of one year or longer must be explained by the provider applicant in writing.

   b. Reasons for any inability to perform the essential functions of the position, with or without accommodation.

   c. Absence of current illegal drug use.

   d. History of loss of license, medical malpractice issues, or felony convictions.

   e. History of loss or limitation of privileges or disciplinary actions.

3. A copy of a current Curriculum Vitae or complete work history must be included with the application packet.

4. Professional providers must possess a current, unrestricted, and valid license to practice and/or provide physical or behavioral health care services in California. The license must have been obtained from the State of California from the appropriate licensing board.

5. If applicable, the provider must have a current medical staff appointment at one or more of VHP's participating hospitals or ambulatory surgery centers, with clinical privileges commensurate with

the services to be performed as a participating provider.

    a. Providers who demonstrate arrangements for hospital admission through another VHP contracted provider are also acceptable.

6. Must be in good standing to provide services under the state and federal programs. Providers must maintain American Board of Medical Specialties (ABMS) certification, or for initial credentialing have completed a specialty residency program, be approved by the American College of Medical Examiners (ACME), American Osteopathic Association (AOA) or other accrediting body acceptable to VHP, as applicable (individually and collectively referred to as "Board"). For professional providers who are initially credentialed and not board certified (NBC), the provider must be Board certified by the next credentialing cycle or provide a written explanation to the Credentialing Committee regarding the lack of Board certification.

    a. Board certified providers will be distinguished from providers who do not have Board certification in the VHP Provider Directory.

    b. A Primary Care Provider (PCP) who was initially credentialed before 2007 and who has not completed a residency in a primary care area will be designated as a General Practitioner in the VHP Provider Directory and will not be obligated to have completed a residency or maintain ABMS certification for recredentialing.

    For providers, who are required to have a federal Drug Enforcement Agency (DEA) Certificate to perform their contractual functions, the provider must possess a verified, current DEA number.

    All providers must have applicable licensure in a current sanction-free status and must never have had revocation without staying or suspension of license or clinical privileges. Providers with any current or past limitations imposed upon the exercise of clinical privileges or any change in appointment of clinical privileges while serving as part of VHP's provider network, must inform VHP during the credentialing process.

7. All providers must furnish evidence of professional Errors of Omissions and/or Malpractice liability insurance coverage in the amounts equal to a minimum of $1 million per occurrence/$3 million aggregate.

    a. Professional liability coverage in amounts equal to a minimum of $1 million per occurrence/$3 million aggregate.

    b. Coverage shall be maintained for a minimum of two years upon completion or termination of the provider contract.

8. VHP also requires the following insurance as part of the provider contracting process:

    a. The Certificates of Insurance shall list the certificate holder as the County of Santa

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Clara, Insurance Compliance.

b. All coverage, except surety, must be issued by companies that hold a current policy holder's alphabetic and financial size category rating of not less than A-V, according to the current Best's Key Rating Guide.

c. Commercial General Liability Insurance (for bodily injury, including death and property damage), which provides liability coverage in amounts equal to a minimum as follows:

> i. $1 million per occurrence/$2 million per general aggregate/$1 million personal injury.

d. General Liability coverage shall include:

> i.Premises and Operations, Personal Injury Liability, and Severability of Interest.

e. Employer's Liability and Workers' Compensation Insurance shall include:

> i. Statutory California Workers' Compensation coverage, including broad form all-states coverage; and
> ii. Employer's Liability coverage in an amount equal to a minimum of $1 million per occurrence.

f. VHP uses a third-party vendor to track and maintain contractual insurance compliance, currently Ebix, Inc (Ebix).

> i. Providers must furnish evidence of their insurance coverage (Certificate(s) of Insurance) to Ebix or may furnish the Certificates of Insurance to VHP directly for uploading into Ebix.

> Certificates of Insurance can be sent directly to Ebix at:
>
> **County of Santa Clara Insurance Compliance**
> **P.O. Box 100085 – ZB**
> **Duluth, GA 30096**
> Email: **countyofsc@ebix.com**
> Fax: **1.770.238.1713**

> Certificates of Insurance can also be sent directly to VHP for transmittal to Ebix:
>
> Email: **ProviderContracts@vhp.sccgov.org**
> Attn: **VHP Insurance Compliance**
> Fax: **1.408.885.7754**
> Attn: **VHP Insurance Compliance**

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9. All providers must possess malpractice liability history determined to be acceptable by the Credentialing Committee. Malpractice liability history includes all legal actions involving claims of medical malpractice which have ever been initiated against the provider. Any provider with a malpractice history will be subject to review and approval by VHP's Credentialing Committee. Acceptance of malpractice history is based on the following guidelines:

   During the five-year period preceding the date of the provider's credentialing application, no more than two legal actions have been commenced and the aggregate amount of the resulting judgments and/or settlements was:

   a. $250,000 or less for the surgical professional provider specialties of obstetrics, neurosurgery, orthopedic, thoracic (cardiovascular and cardiac), and plastic surgery; or

   b. $100,000 or less for other specialty professional providers and PCPs will be subject to review and approval by the Credentialing Committee.

      VHP reserves the right to consider the review of providers who do not meet one or more of the minimum standards and will be considered and presented to the Credentialing Committee as a special consideration.

10. All providers must demonstrate to the satisfaction of VHP the capability to provide physical and/or behavioral health care services to VHP's members that meet the standards established by VHP.

11. All providers are responsible for organizing a pattern of supportive health care resources and services so that VHP's members are appropriately provided medical advice and supervision seven days a week and 24 hours a day.

12. Within the five-year period preceding the date of the provider's credentialing application the provider's medical staff appointment or clinical privileges have not been denied, revoked, or terminated by any health care facility.

In addition to meeting the above-listed minimum requirements, all providers must:

1. 1.Agree to actively participate in and comply with VHP's utilization review and quality improvement activities and permit VHP representatives to have access to the physical location where services are rendered for the purpose of conducting on-site audits.

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Agree to comply with VHP standards, protocols, policies, and provisions specified in the Provider Agreement, as applicable.

> **Note:** VHP reserves the right to terminate a provider from the VHP network at any time.

Following the credentialing/recredentialing process, the provider is required to notify VHP within five calendar days if any of the following circumstances arise:

- Surrender, revocation, or suspension of a license or current DEA registration;
- Exclusion of provider from any federal program for payment of physical or behavioral health care services;
- Filing of any report regarding the provider to NPDB or with a state licensing or disciplinary agency;
- Change of a provider's status that results in any restrictions or limitations; or
- External sanction or corrective action levied against a provider by a governmental entity.

Such notice shall be sent in writing and in accordance with the "Notice" provision set forth in the provider's agreement to VHP's Provider Credentialing Department at 2480 N. 1st Street, Suite 160, San Jose CA 95131.

Specialized Participation as a PCP or Human Immunodeficiency Virus (HIV) Specialist

To qualify to participate as a VHP PCP, a provider must meet the following additional qualifications:

a. Have an active license to practice medicine in Family Practice, General Practice, Internal Medicine, Obstetrics/Gynecology or Pediatrics.

b. Be willing and able to conduct the following activities on behalf of VHP members:

i. Supervise, coordinate, and provide initial and basic care;
ii. Initiate referrals for specialist care; and
iii. Maintain continuity of patient care in accordance with applicable VHP policies and the Provider Agreement.

c. Be willing and able to accept members and serve as a PCP.

To qualify to participate as an HIV/Acquired Immunodeficiency Syndrome specialist, a provider must meet the following additional qualifications:

1. Provider must complete and sign the AIDS/HIV Attestation form required under Assembly Bill

(AB) 2168 found in the **Appendix.**

2. Provider must be Board certified in Infectious Disease and meet one of the following criteria:

    a. In the past 12 months, provided clinical management to at least 25 HIV patients and completed 15 hours of Category 1 CME in HIV Medicine, five (5) hours of which were related to antiretroviral therapy; or

    b. In the past 24 months, provided clinical management of 20 HIV patients and, in the past 12 months, completed board certification in Infectious Disease; or

    c. In the past 24 months, provided clinical management of 20 HIV patients and, in the past 12 months, completed 30 hours of Category 1 CME in HIV Medicine; or

    d. In the past 24 months, provided clinical management of at least 20 HIV patients and, in the past 12 months, completed 15 hours of Category 1 CME in HIV Medicine as well as successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine (AAHIVM).

> **Note:** On an annual basis, the Credentialing Department reconfirms the qualifications of the HIV specialist.

Provider Recredentialing

To comply with regulatory and accreditation standards, VHP recredentials providers at least every 36 months from the date of the initial credentialing decision. The recredentialing process incorporates re-verification and identification of changes in the provider's license, sanctions, certifications, malpractice reports, health status, and/or performance information, such as professional conduct and competence. The recredentialing process includes primary source verification and is reviewed every three years per NCQA standards.

In between credentialing cycles, VHP may conduct ongoing or continuous monitoring activities of VHP network providers. This includes an inquiry to the appropriate and applicable regulatory agencies if/when VHP identifies newly disciplined providers or providers with a negative change in their current licensure status. Additionally, VHP reviews monthly reports released by the Office of Inspector General (OIG) and applicable sanction databases to identify network providers who have been newly sanctioned or excluded from participation in any state or federal health care program.

A provider's agreement may be terminated at any time if VHP's Credentialing Committee determines that the provider no longer meets VHP's credentialing standards and requirements.

Provider's Right to Review and Correct Information

A provider participating in VHP's provider network has the right to review information obtained by VHP used to evaluate the provider's credentialing and/or recredentialing applications. This includes information obtained from any outside primary source such as the NPDB, malpractice insurance carriers and state licensing agencies.

Should a provider identify any erroneous information or discrepancies used in the credentialing/recredentialing processes, or should any information gathered as part of the primary source verification process differ from that submitted by the provider, the provider has the right to correct any erroneous information submitted by another party. To request release of such information, a provider must submit a written request to VHPs Provider Credentialing Department. Upon receipt of this information, the provider has 14 calendar days to provide a written explanation detailing the error or the difference in information. VHP's Credentialing Committee will then include the information as part of the credentialing/recredentialing process.

To submit a written request for release of information, contact VHP's Provider Credentialing Department at **credentialing@vhp.sccgov.org** or **1.888.421.8444** (For TTY, contact California Relay by dialing **711** or **1.800.735.2929**).

Right to Be Informed of Application Status

All providers who have applied to join the VHP provider network have the right to be informed of the status of their application upon request. To obtain status, contact VHP's Provider Credentialing Department at **credentialing@vhp.sccgov.org** or **1.888.421.8444** (For TTY, contact California Relay by dialing **711** or **1.800.735.2929**).

Right to Appeal Adverse Credentialing Determinations

VHP reserves the right to discontinue a provider's participation in VHP's network for any reason including for example, quality of care or liability claims issues. In such cases, the provider has the right to request reconsideration in writing within 14 calendar days of formal notice of denial or termination. All written requests should include additional documentation to support reconsideration of participation in the VHP network. The Credentialing Committee will review the reconsideration request no later than 60 calendar days from the receipt of the additional documentation. VHP will send a written response to the provider's reconsideration request within 14 calendar days of the final decision.

Sanction Monitoring

VHP has established an ongoing monitoring program, to help ensure continued compliance with credentialing standards and to assess and monitor issues of substandard professional conduct and competence. This is achieved by monitoring sanction activity from medical boards, state, federal and

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other regulatory bodies every 30 calendar days. If VHP finds that a provider has been identified by one of these sources, it is brought to the Credentialing Committee to discuss and decide on any action necessary up to and including termination from VHP's provider network.

Credentialing Committee

The Credentialing Committee is responsible for establishing and adopting as necessary, criteria for provider participation in VHP's network. It is also responsible for oversight and direction of the credentialing procedures, including provider participation, denial, and termination.

VHP's Credentialing Committee consists of the Chief Medical Officer (CMO), or an appointed designee, and at least three non-VHP external providers, including physicians and mid-level professionals representing multiple physical and behavioral specialties (e.g., Psychiatry) or practice types. Credentialing Committee meetings are held at least monthly and more often as deemed necessary.

Providers are notified of the Credentialing Committee's decision within 30 calendar days or as required by state law. Providers are notified in writing that they have the right to review information submitted with their credentialing applications. This right includes access to any information obtained from outside sources, except for peer review as described more fully in the Section entitled "Provider's Right to Review and Correct Information."

Submitting Provider Data for Delegated Independent Physician Association (IPA)/Provider Groups

> If an IPA/provider group has been delegated for credentialing, VHP has a standard roster format in which the IPA/medical group must submit their provider data monthly. This standard roster template can be obtained by contacting Provider Relations at **providerrelations@vhp.sccgov.org** or **1.888.421.8444** (for TTY, contact California Relay by dialing **711** or **1.800.735.2929**). A copy of the Delegated Import Roster is included in the **Appendix**.

Delegated Credentialing Requirements

VHP adheres to the regulatory and NCQA accreditation standards incorporated into its policies and procedures for credentialing and recredentialing of providers and other licensed health care professionals, facilities and mid-levels that provide physical and behavioral health care services to VHP members. At its sole discretion, VHP may delegate credentialing activities to a medical group, IPA, or organization that demonstrates compliance with VHP's credentialing and recredentialing standards.

Compliance with VHP's credentialing and recredentialing standards is demonstrated through a pre-delegation review performed by VHP's Credentialing Department working in collaboration with VHP's

Compliance Department. The results of the pre-delegation audit are presented to the Credentialing Committee. The pre-delegation audit includes a review of the delegate's credentialing policies and procedures, as well as an audit of their credentialing files. The IPA/medical group will be obligated to execute a Delegate Agreement with VHP and adhere to the terms set forth therein.

For every year after the initial audit, VHP may choose to perform a desk top delegated credentialing audit. VHP retains the right to conduct an annual evaluation of the delegate in the same manner as conducted during the pre-delegate review. As part of the oversight process, VHP may choose to utilize the ICE shared survey or elect to use the current facility site review (FSR) survey tool (see Chapter 8, "Facility Site, Physical Accessibility and Medical Records Review").

The final determination of the qualifications of individual practitioners or organizational facilities to participate with VHP will be determined solely by VHP. A delegated credentialing entity shall comply with the credentialing policies and procedures specified by VHP.

An alternate credentialing application, which collects the same information as VHP's credentialing application, may be utilized with prior approval of VHP. The delegated IPA/medical group credentialing entity will maintain the original provider credentialing applications at their physical location. The delegated credentialing entity shall also provide VHP, either electronically or in hard copy, with a report detailing certain data elements for each provider. The format of this report is specified in the Delegated Import Roster included in the **Appendix**.

The delegated credentialing entity is also required to provide VHP, on at least a monthly basis, reports that may include, at a minimum, additions, terminations and changes to the delegate's provider network, and other information as may be agreed upon in the IPA/medical group's Delegate Agreement or as otherwise required on the Delegated Import Roster.

The delegated credentialing entity shall provide VHP with five days' notice of any disciplinary action taken against a participating provider and/or any change in the provider's appointment status or restriction of license and/or limitation on the provider's clinical privileges. Such notice shall be sent in writing and in accordance with the "Notice" provision set forth in the provider's agreement to VHP's Provider Credentialing Department at 2480 N. 1st Street, Suite 160, San Jose CA 95131.

VHP reserves the right to request the minutes from the delegated credentialing entity's Credentialing Committee involving its participation determinations.

Recommendation for initial and continued participation of providers for whom the credentialing process has been completed by a delegated credentialing entity will be made to the VHP's Credentialing Committee in accordance with the criteria specified in VHP's policy. VHP retains the final decision on inclusion of a provider's participation in VHP's participating provider network.

Corrective Action Plans

If a delegated credentialing entity does not achieve compliance with VHP's Delegate Agreement setting forth VHP's requisite standards of performance, VHP may require a corrective action plan (CAP) to remediate those areas requiring performance improvement. If compliance with the CAP is not achieved within a predetermined timeframe, VHP may continue oversight of the delegated credentialing activities. VHP may revoke delegated functions if there is continued non-compliance with the credentialing standards or an inability to demonstrate compliance with the CAP.

Credentialing Reporting Requirements for Delegated Credentialing Entities

In addition to complying with state and contractual requirements, VHP requires all delegated credentialing entities to adhere to notification procedures as outlined in the provider's Delegate Agreement. For example, the delegated credentialing entity must provide prior written notice to VHP of the addition or termination of any new providers or other licensed health care professionals. For providers with changes to their credentialing information, the following must be included as part of the monthly submission of the Delegated Import Roster to VHP which can be found in the **Appendix** or obtained by contacting VHP's Provider Credentialing Department at **credentialing@vhp.sccgov.org** or **1.888.421.8444** (For TTY, contact California Relay by dialing **711** or **1.800.735.2929**):

- Demographic information including, but not limited to, name, gender, specialty, and IPA/medical group address(es) and locations

- California license

- DEA registration

- Education and training, including board certification status and expiration date

- Facilities or ambulatory surgery centers at which the provider has privileges, or coverage arrangements

- Billing information, which includes:

  o Legal entity name

  o Billing address

- TIN

- Product participation (e.g., Commercial Classic and/or Preferred, IFP, or Covered California)

- Languages spoken and written by the care provider or clinical staff

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Reporting Changes

The delegated credentialing entity must ensure that it and its providers communicate and maintain current demographic information and/or changes to participation and panel status with VHP. Changes include:

- Address

- TIN

- Panel status of accepting patients:

    o Open

    o Closed

    o Existing only

- Product participation

Demographic changes and changes to panel status, product participation or termination from the IPA/ medical group must be reported to VHP in accordance with the Delegate Agreement. Failure to notify VHP as specified in the Delegate Agreement may result in revocation of the credentialing delegation. If the credentialing delegation is revoked by VHP, VHP may consider conducting a pre-delegation audit no earlier than the next three-year credentialing cycle.

Delegate Reporting of Terminations

The delegate must notify VHP in writing of terminations of providers or other licensed health care professionals. VHP must receive such notice 90 calendar days in advance of the termination effective date. Notification from the delegated credentialing entity to VHP must include the following:

- Reason for termination of the provider;

- Effective date of termination; and

- Recommendation for reassignment of members precipitated by the termination of a PCP affiliated with the IPA/medical group.

When a PCP terminates their affiliation with a delegated credentialing entity or IPA/medical group, VHP's members generally have two options:

- Stay with their existing IPA/medical group and change their PCP; or

- Transfer to another IPA/medical group to continue care with their existing PCP.

Members may change their PCP prospectively as described in their benefit plan.

VHP retains sole responsibility for the reassignment of members. VHP's reassignment activities are intended to preserve continuity of patient care with the existing PCP and to consider the desire of the

member for continuation of care, language preference and geographic location. In the event a PCP terminates with an IPA/medical group and the PCP has an affiliation with another IPA/medical group, VHP may assign the member to the other IPA/medical group with which the PCP has a current affiliation.

Negative Actions Reporting Requirements

The delegated credentialing entity is required to notify VHP in writing within five calendar days of any of the following actions taken by or against a PCP, specialist, or other licensed health care professional, as applicable:

- Surrender, revocation, or suspension of a license or current DEA registration;
- Exclusion of provider from any federal program for payment of medical services;
- Filing of any report regarding the provider to NPDB or with a state licensing or disciplinary agency;
- Change of a provider's status that results in any restrictions or limitations;
- When the delegated credentialing entity reasonably determines serious deficiencies in the professional competence, conduct or quality of care of the provider that affects, or could adversely affect, the health and safety of the member; or
- External sanction or corrective action levied against a provider by a governmental entity.

Such notice shall be sent in writing and in accordance with the "Notice" provision set forth in the provider's agreement to VHP's Provider Credentialing Department at 2480 N. 1st Street, Suite 160, San Jose CA 95131.

The final determination of the qualifications of a provider to participate in VHP's participating provider network will remain solely within the authority of VHP.

Facility or Organizational Credentialing Requirements

VHP credentials organizational providers prior to contracting and every 36 months thereafter. In accordance with VHP's accrediting agency standards, VHP credentials the following organizational providers, which include, but are not limited to:

VHP contracts with accredited organizational providers as defined below that have been approved either by a recognized accrediting body or have passed a Centers for Medicare and Medicaid Services (CMS) or California state site review in lieu of a site visit by VHP. Those that are unaccredited are considered for network participation by exception only. Critical network needs must be documented by the Provider Relations or Provider Contracts Administration departments and the unaccredited organizational provider must achieve a passing score from the state's/CMS's site survey. The CMS or state review may not be greater than three years old at the time of verification.

Organizational Provider	Possible State & Federal Regulatory Bodies	Possible Accrediting Bodies
Hospitals	• Clinical Laboratory Improvement Amendments (CLIA) program • Centers for Medicare and Medicaid Services (CMS) (**www.cms.gov**) • California Department of Public Health (CDPH)	• Centers for Medicare and Medicaid Services (CMS) (**www.cms.gov/Regulations-and-Guidance/ Legislation/CLIA**) • The Joint Commission (TJC) (**www.jointcommission.org)** • Healthcare Facilities Accreditation Program (HFAP) (**www.hfap.org**) • Det Norske Veritas Healthcare, Inc. (DNV) (**www.dnvglhealthcare.com**) • Center for Improvement in Healthcare Quality (CIHQ) (**www.cihq.org**)
Home Health Agencies	• CMS • State licensing board	• TJC • Community Health Accreditation Program (CHAP) (**www.chapinc.org**) • Accreditation Commission for Health Care (ACHC) (**www.achc.org**)
Skilled Nursing Facilities	• CLIA • CMS • State licensing board	• TJC • Continuing Care Accreditation Commission (CCAC) (**www.carf.org**) • Commission on Accreditation of Rehabilitation Facilities (CARF) (**www.carf.org**)
Free Standing Surgical Centers	• CLIA • CMS • State licensing board	• Ambulatory Health Care (AAAHC) (**www.aaahc.org**) • TJC • American Accreditation Association for Accreditation for Ambulatory Surgery Facilities (AAAASF) (**www.aaaasf.org**) • HFAP

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Organizational Provider	Possible State & Federal Regulatory Bodies	Possible Accrediting Bodies
Behavioral Health	• CMS • State licensing board	• TJC • Council on Accreditation (COA) (**www.coanet.org**) • CARF • HFAP
Durable Medical Equipment (DME)	• CMS • State licensing board	• CARF • The Compliance Team (TCT) (**www.thecomplianceteam.org**) • American Board for Certification in Orthotics & Prosthetics (ABC) (**www.abcop.org**) • CHAP • ACHC • Board of Certification/Accreditation (BOC) (**www.bocusa.org**) • HealthCare Quality Association on Accreditation (HQAA) (**www.hqaa.org**) • National Association of Board of Pharmacy (NABP) (**https://nabp.pharmacy**) • TJC • Other CMS approved sources
Diagnostic Imaging Centers	• Business license	• American College of Radiology (ACR) (**www.acr.org**) • TJC
Clinical Laboratory	• CLIA • California Department of Public Health (CDPH) (**www.cdph.ca.gov**)	• Commission on Office Laboratory Accreditation (COLA) (**www.cola.org**) • The College of American Pathologists (CAP) (**www.cap.org**)

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Credentialing and Recredentialing Application Requirements – Organizational Providers

1. As part of the initial credentialing and on-going recredentialing processes, organizational providers must submit the following documentation:

    a. Proof of good standing with applicable state and federal regulatory bodies, as listed in as listed in the grid above.

    b. Proof of accreditation, within the previous three years, by one of the accrediting bodies, as listed in the grid above, or

    c. If not accredited, evidence of review and approval by CMS or California oversight body within the previous three years.

        i. Organizations may be under a CAP by the California oversight body at the time evidence of accreditation is provided to VHP.

        ii. If VHP's Chief Medical Officer or designee determines that the CAP does not pose significant quality issues that would affect the quality of care or service to members, the organizational provider may be considered for participation in VHPs provider network.

CH 10:
Primary Care Providers & Other Providers

This Chapter Includes:

!	**Alert** Alert draws attention to critical information that has changed this year.
📞	**Contact** Contact information on who to contact for assistance.
VHP	**Book Table of Contents** Click the purple VHP circle logo, located at the bottom left corner, to return to the main TOC.

The primary care provider (PCP) is the foundation of VHP's service delivery model. While the PCP plays a vital role, all VHP's network providers play critical roles to ensure that VHP's members receive the care they need at the right time and at the right site of service. VHP is committed to working with its providers, community organizations, and other groups to provide quality access to care to all VHP members. Below are the provider responsibilities for all contracted providers.

Provider Types That May Serve as PCPs

The health care professionals allowed to serve as PCPs include the following specialties, but are not limited to:

- Internal Medicine
- Pediatrics
- Obstetrics/Gynecology
- Family and General Practice

The PCP may practice in a solo practice or group setting or at a Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Indian Health Center (IHC) or an outpatient clinic.

PCP Responsibilities

VHP members select a PCP who is responsible for coordinating the delivery of all health care services to the member, including referrals to appropriate specialists. This is accomplished through access to care 24 hours a day, seven days a week. Each PCP is assigned to a network (e.g., multi-specialty group practice, independent practice association, VHP direct provider network, etc.). Based on the member's selection of their PCP and the network affiliation of the PCP, referrals should be directed into the network associated with the PCP. The member's network is considered "preferred" for the purposes of referrals for specialty, hospital, and ancillary services. VHP will approve referrals outside the member's preferred network in select circumstances, including for example, the absence or unavailability of a specialist in the member's primary network or if the member requires services offered by a tertiary or quaternary hospital.

PCPs are responsible for the following activities:

1. Ensuring or facilitating member access to the health care system, preventive care, and appropriate treatment interventions;
2. Providing quality primary physical and behavioral health care services including preventive medical services;
3. Conducting health risk assessments and all other required assessments
4. Initiating and coordinating referrals to specialists or other contracted providers as medically indicated;
5. Assuring that members are not discriminated against in the delivery of services based on

race, ethnicity, national origin, spoken language, religion, sex, age, mental or physical disability or medical condition, sexual orientation, gender identify, claims experience, medical history, evidence of insurability, disability, genetic information, and/or source of payment.

6. Following up with a member after an acute hospitalization and/or emergency room visit;

7. Assuring that no unnecessary or duplicate physical or behavioral health care services are provided;

8. Establishing a good medical record system for tracking, recalling, and identifying any clinical problems unique to members;

9. Providing basic case management services in collaboration with VHP's Case Management Department including, at a minimum:

    a. Assisting with the identification of members in need of case management services;
    b. Communicating directly with the member, family and/or VHP Case Management staff; and
    c. Participating in initial and ongoing training and education related to VHP's case management and care coordination services;

> ⚠ See **Chapter 18, "Case Management"** for further information about the case management services available from VHP.

10. Identifying and following up with any member who has missed or cancelled his/her appointment;

11. Establishing and maintaining hospital admitting privileges at one of VHP's network hospitals or ambulatory surgery centers sufficient to meet the needs of VHP members or, enter an arrangement for management of inpatient hospital admissions of members at one of VHP's network hospitals;

12. Managing the physical and behavioral health care needs of members to assure that all medically necessary services are made available in a culturally responsive and timely manner while ensuring patient safety at all times, including members with disabilities and chronic conditions;

13. Maintaining a current and complete medical record for the members in a confidential manner, including documentation of all services and referrals provided to the members, including, but not limited to, services provided by the PCP, specialist, and providers of ancillary services;

14. Following established procedures for coordination of in-network and out-of-network services for members, including obtaining authorizations for VHP specified inpatient and outpatient services, except for emergency services up to the point of stabilization, as well as coordinating services the member is receiving from another provider during a transition of care;

15. Actively participating in and cooperating with VHP's quality initiatives and utilization, quality, and case management programs;

16. Scheduling an initial Health Risk Assessment (HRA) for a new member within 120 calendar days

of assignment by VHP;

17. Ensuring that referrals are pre-approved by VHP and directed to providers associated with the network chosen by the member and reflected on the member's ID card. Exceptions may be made for extenuating circumstances including for example, when the member's network does not have availability, or the services needed by the member; and

18. Ensuring that referrals for elective, acute care hospital services are pre-approved by VHP and are cognizant of the level of care required for treatment of the member's condition or disease. For example, in urgent or emergent situations, Stanford Health Care and Lucille Packard Children's Hospital are contracted by VHP for tertiary and quaternary care only.

Assignment of the Primary Care Provider

PCPs must see members who select them or who are assigned to them by VHP. Not all members select a PCP when enrolled with VHP. As a result, VHP's initial priority is to make certain every member has a PCP. VHP's Member Services staff are trained on the PCP selection process and helping members to establish a relationship with a PCP. In the event a member does not select a PCP, VHP will assign the member to a PCP in its network based on, but not limited to, PCP's acceptance of new members, geographic location, and language preference.

A. PCP Selection and Assignment

1. VHP members may select a PCP or be assigned a PCP effective the first day of the month following enrollment. If a member does not choose a PCP, VHP will assign the member to a PCP.

2. PCPs are responsible for rendering all standard primary care services to VHP members in accordance with the VHP or Department of Managed Health Care (DMHC) access to care guidelines.

B. PCP Member Assignment Responsibility

1. PCPs are responsible for verifying member eligibility and PCP assignment prior to rendering primary care services.

C. Changing Assigned PCP

1. If a member is not assigned to a PCP at the time service is requested and the member would like to switch to a different PCP, the member may request a PCP change to be effective on the first day of the following month by one of the following methods:

   i. Contact the VHP Member Services Department at **1.888.421.8444** to speak with a member service specialist who can assist with PCP selection.
   ii. Email VHP's Member Services Department at **Member.services@vhp.sccgov.org** to request a PCP change.

2. All changes will be effective the first day of the month following the date VHP received the request for a PCP change.

D. Unassigned PCP Claims Denials

1. If a PCP sees a VHP member who is not assigned to the PCP's panel, the claim is subject to denial by VHP, and in such instances the PCP will not be eligible to bill the member for payment for the services rendered.

E. Redirection of Members for Primary Care Services

1. If a member attempts to see a PCP who is not assigned to the member, and the member is unwilling or refuses to request a change in PCP assignment, the PCP office has the right to decline to render services to the member and may redirect the member back to VHP for assistance or directly to the member's assigned PCP.

Member Panel Capacity

PCPs reserve the right to state the number of members they are willing to accept into their panel. VHP will not guarantee the number of members the PCP will be assigned by VHP. The number of members a PCP or a specialist can serve shall not exceed the following ratios:

- **Primary Care: 1:2,000**
- **Specialists: 1:1,200**

If a PCP would like to change the number of VHP members assigned to their practice, the PCP must contact Provider Relations at **1.888.421.8444**. The change to membership assignment will immediately take effect, if the current total number of members does not exceed the newly requested limit. If the new requested limit exceeds the current number of members, VHP requires a 30-calendar-day notification for membership notification and reassignment.

> A provider may not refuse to treat a VHP member if the provider has not reached the requested panel size limit or the ratios set forth above, as applicable.

Continuity of Care for Existing Relationships

VHP recognizes the importance of the patient-PCP relationship and strives to maintain the established continuity of care for its members during the PCP assignment process. Some members may have an existing patient-PCP relationship prior to their enrollment with VHP. If the pre-existing relationship is with a PCP who is contracted by VHP, VHP makes every effort to assign the member to that PCP in VHP's eligibility system and to generate and issue an ID card that reflects the assignment of the member to the existing PCP.

If a member has been receiving services from a provider who is not contracted with VHP, and the member wishes to continue to receive services from the provider, the member may contact the Member Services Department to speak to a member services specialist at **1.888.421.8444** who can assist the member with requesting consideration for continuity of care. Refer to Chapter 17, "Utilization Management" for detailed information on continuity of care requests.

Access Standards

VHP follows the appointment accessibility requirements as determined by DMHC and applicable regulatory and accrediting agencies. Providers are encouraged to participate in VHP's timely access and appointment accessibility and availability audits. VHP monitors compliance with the appointment accessibility standards on at least an annual basis and uses the results of appointment standards monitoring to achieve adequate appointment availability and reduce unnecessary emergency room utilization. All providers are required to adhere to VHP and DMHC's timely access standards. VHP's annual audit may result in the implementation of a corrective action plan (CAP) by the provider and may be considered in the recredentialing process for the specific provider under review. See Chapter 12, "Timely Access Requirements."

Referrals

PCPs are encouraged to refer a member when medically necessary care is beyond the scope of what the PCP can provide. The PCP must obtain prior authorization from VHP for referrals to certain specialty providers as noted in Chapter 17, "Utilization Management."

> **Note:** PCPs are affiliated with their independent medical association (IPA)/medical group (MG) in VHP's core operating system and referrals for services outside the member's chosen network may require prior approval by VHP. If you are part of an IPA/MG, work with the IPA/MG to ensure compliance with the IPA/MG's referral authorization process.

Standing Referrals

A member may request a standing referral to a participating specialist, ancillary provider, or specialty care center if a member requires ongoing specialist treatment, has a life-threatening condition or disease, or a degenerative and disabling condition or disease. This referral is available only if the condition or disease requires specialized medical care over a prolonged period. The specialist or ancillary provider must have the necessary medical expertise and be properly accredited or designated to provide the medically necessary care required for the treatment of the condition or disease. Standing referrals to non-VHP contracted specialists, ancillary providers or specialty centers will only be approved if the service is not otherwise available in the member's chosen network and from VHP's contracted specialist and ancillary preferred network.

Examples of standing referrals include but are not limited to:
- End Stage Renal Disease
- Transplants
- Oncology/Radiation/Chemotherapy
- HIV/AIDS

Member Self-Referrals

VHP permits members to obtain certain services without a referral from the PCP. The following health care services do not require a referral provided through the member's chosen network or VHP's preferred, contracted provider network:
- Obstetrics/gynecology services
- HIV testing and counseling
- Tuberculosis diagnosis and treatment
- Selected routine outpatient diagnostic services (i.e., routine laboratory tests, ultrasounds, x-rays, fetal non-stress testing) assuming these routine services are performed as part of a VHP approved visit to a specialist or performed by the PCP
- Immunizations
- Certain preventive service
- MDLive telehealth visits for urgent care and behavioral health services

Referrals to Specialists

The PCP is responsible for coordinating the health care services for VHP members. PCPs can refer a member to a specialist in the member's chosen network when care is needed that is beyond the scope of the PCP's training or practice parameters. PCPs may refer members to a provider not contracted by VHP, affiliated with the member's chosen network, or contracted in VHP's preferred provider network in the event the specialist needed for the member's condition is not available. However, PCPs must obtain prior authorization from VHP for referrals to providers not contracted by VHP or not affiliated with the member's chosen network. The specialist making the referral is responsible for informing the PCP of the member's status and proposed interventions throughout the course of the specialist's treatment.

Specialist Responsibilities

VHP encourages specialists to communicate with the member's PCP if there is a need to make a referral to another specialist rather than making such a referral without the PCP's involvement. This allows the PCP to be aware of the additional requested services and provides for better coordination of the member's care. This also ensures that the specialist to whom the member was referred is a contracted provider

within the VHP network. The specialist may order diagnostic tests without the PCP's involvement by following VHP's referral guidelines as set forth in <u>Chapter 17: "Utilization Management."</u>

Emergency admissions require notification to VHP's Utilization Management Department within 24 hours of admission. Elective admissions require prior authorization from the Utilization Management Department.

Specialists must:

- Maintain communication and on-going contact with the PCP;

- Obtain authorization from VHP's Utilization Management Department, if needed, prior to rendering services;

- Coordinate the member's care with the PCP;

- Provide the PCP with consult reports and other appropriate records within five business days of completing the services requested in the referral;

- Be available for, or provide, on-call coverage through another source 24 hours a day, seven days a week for the management of the member's care;

- Maintain confidentiality of medical information; and

- Actively participate in and cooperate with VHP's quality initiatives and utilization guidelines and quality and case management programs.

VHP providers should refer to their participating provider agreement for complete information regarding the provider obligations and reimbursement or contact their assigned Provider Relations Specialist with any questions or concerns.

Hospital Responsibilities

VHP uses a network of hospitals to deliver inpatient and other hospital-based services to VHP members. All services must be provided in accordance with applicable state and federal laws and regulations.

Hospitals must:

- Obtain authorization for inpatient and specified outpatient services as specified in <u>Chapter 17, "Utilization Management"</u> and listed in the member's current Evidence of Coverage (EOC), which is located on VHP's website. (**www.valleyhealthplan.org**), except for emergency stabilization services.

- Notify VHP's Utilization Management Department of an admission within 24 hours of admission.

- Notify VHP's Utilization Management Department of all specialty care nursery/newborn intensive care unit (NICU) admissions within 24 hours of admission.

VHP's Utilization Management Department can be notified of an admission by faxing the Inpatient Face Sheet to **1.408.885.4875** or by calling **1.408.885.4647**.

CH 11:
Locum Tenens

This Chapter Includes:

!	**Alert**	Alert draws attention to critical information that has changed this year.
📞	**Contact**	Contact information on who to contact for assistance.
VHP	**Book Table of Contents**	Click the purple VHP circle logo, located at the bottom left corner, to return to the main TOC.

Who is a locum tenens provider?

A locum tenens provider is a provider who is sponsored by or otherwise retained by a VHP contracted provider on a temporary basis, not to exceed 60 calendar days, to provide services to the contracted provider's patients. The contracted provider must be currently employed at that location.

VHP does not contract with or make any representation regarding a locum tenens provider's qualifications or competency. All liability for the acts or omissions of a locum tenens provider rests with the provider or organization retaining the services of the locum tenens.

The locum tenens must be the same type of provider as the authorizing provider (e.g., an MD/DO can only authorize another MD/DO as a locum tenens, a DC can only authorize another DC, etc.). To be considered for locum tenens status, the temporary provider must be one of the following provider types:

- **Doctor of Medicine (MD)**
- **Doctor of Podiatry (DPM)**
- **Doctor of Optometry (OD)**
- **Doctor of Osteopathy (DO)**
- **Doctor of Chiropractic (DC)**
- **Physical Therapist (PT)**

Temporary Transfer of Responsibility

Provider agreements obligate PCPs to establish and maintain coverage 24 hours a day, seven days a week. However, personal illness, sabbatical or maternity leave are examples of times when brief withdrawal from a practice and temporary transfer of this responsibility may be necessary. In the event the provider must withdraw from his/her practice for a planned period of time (e.g., maternity leave), VHP, at its discretion, may agree that a locum tenens provider may be engaged by the PCP to provide coverage for a limited and specified period of time. The provider must arrange for this coverage and provide VHP with written notice of the temporary transfer of responsibility to a locum tenens provider acceptable to VHP.

The provider requesting a temporary transfer of responsibility must include in the arrangement with the locum tenens provider the ability to terminate, without cause and effective upon notice, the locum tenens provider's provision of services with respect to VHP's members. If the intended interruption will exceed 60 calendar days, VHP may close the provider's panel, since absence beyond 60 calendar days does not allow for direct patient management. Sustained periods of unavailability are not in the best interest of VHP's members, as members are unable to access their chosen PCP. If a PCP's temporary transfer of responsibility extends beyond 60 calendar days and involves unique circumstances, the provider requesting temporary transfer of responsibility must contact the Provider Credentialing Department for further guidance at **1.408.885.2221** or **credentialing@vhp.sccgov.org**.

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Locum tenens providers will not be listed in the VHP Provider Directory and are not permitted to have a panel of members.

How to Submit Claims for Rendered Services

Locum tenens providers must bill for their services under the name and tax identification number (TIN) of the provider the locum tenens is replacing. However, the locum tenens provider must provide their National Provider Identifier (NPI) number. Locum tenens providers must be licensed in the state in which they are practicing and must only perform services within the scope of their professional license and certification.

When billing for rendered services as a locum tenens, the provider should use the modifier for substitute Physician (Q5), and locum tenens (Q6) as a covering provider.

> **Note:** If a provider organization plans to utilize a locum tenens for a period of 60 calendar days or longer, the locum tenens provider must be credentialed by VHP. The contracted provider must notify VHP prior to commencement of the use of the locum tenens, if possible, and if not possible, then immediately notify VHP to allow sufficient time for the credentialing process.

Covering Provider

A covering provider is responsible for emergent or urgent care only. Follow-up treatment must always occur with the member's PCP or a VHP specialist. All VHP providers have contractually agreed to be accessible to members 24 hours per day, seven days per week. If a provider is not available, the provider is responsible for maintaining appropriate coverage. VHP requires that all covering providers be contracted and credentialed. A written notification of the termination or addition of covering providers must be sent to Provider Data Management 30 calendar days prior to the start or termination of the provider by calling **1.408.885.2566** or emailing **providerdatamgt@vhp.sccgov.org**.

VHP requires that covering providers with the potential to treat VHP members be enrolled and credentialed. Enrollment and credentialing will be valid for up to six months.

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CH 12:
Timely Access Requirements

This Chapter Includes:

1. **Timely Access Standards**

2. **Exceptions to Time-Elapsed Standards**

3. **Triage and Screening Services**

4. **Nurse Advice Line**

5. **Timely Access Monitoring**

(!)	**Alert** Alert draws attention to critical information that has changed this year.
☎	**Contact** Contact information on who to contact for assistance.
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VHP and DMHC have established expectations and standards regarding provider accessibility. These expectations and standards help VHP's members obtain appointments and receive services within specific required timeframes. All providers are required to adhere to the timely access standards set forth below.

Timely Access Standards

Primary Care Providers (PCPs)

Appointment Type or Service	Criteria	Standard Access Timeframe
Urgent Appointment	Immediate care is not needed for stabilization, but if not addressed in a timely way could escalate to an emergency.	Appointment offered within 48 hours of request.
Non-Urgent/Routine Appointment	Immediate care is not needed. For example, this appointment type could be related to new health issues or a follow-up appointment for existing health problems.	Appointment offered within10 business days of request.

Specialists

Appointment Type or Service	Criteria	Standard Access Timeframe
Urgent Appointment	Immediate care is not needed for stabilization, but if not addressed in a timely way could escalate to an emergency.	Appointment offered within 96 hours of request.
Non-Urgent/Routine Appointment	Immediate care is not needed. For example, this appointment type could be related to new health issues or a follow-up appointment for existing health problems.	Appointment offered within15 business days of request.

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Obstetrics and Gynecology

Appointment Type or Service	Criteria	Standard Access Timeframe
First Prenatal Visit	Immediate care is not needed.	Appointment offered within 2 weeks of request.

Behavioral Health Providers

Appointment Type or Service	Criteria	Standard Access Timeframe
Non-Life-Threatening Emergency Appointment	Immediate assessment or care is needed to stabilize a condition or situation, but there is no imminent risk of harm to self or others.	Appointment offered within 6 hours of request.
Urgent Appointment	Immediate care is not needed for stabilization, but if not addressed in a timely way could escalate to an emergency.	Appointment offered within 48 hours of request.
Routine (Non-Urgent) Appointment	An assessment of care is required with no urgency or potential risk of harm to self or others.	Appointment offered within 10 business days of request.
Follow Up Routine Appointment	Follow-up care is required for non-urgent/routine care.	Appointment offered within 30 business days of request.

Other Provider Types and Facilities

Appointment Type or Service	Criteria	Standard Access Timeframe
Appointment Type or Service	Criteria	Standard Access Timeframe
Ancillary	Diagnosis or treatment of injury, illness, or other health condition.	Appointment offered within 15 business days.

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Pharmacy	Dispensing of a covered outpatient drug in an emergency.	Provide at least a 72-hour supply of a covered outpatient drug.
Skilled Nursing Facility (SNF)	Patient's functional or medical complexity are such that the outcome would be compromised with less than daily skilled services.	Provide service within 5 business days.
Intermediate Care Facility (ICF)	Services for developmental disabilities.	Provide service within 5 business days.

After-Hours Accessibility

Services	Standard Access Timeframe
Automated System, Office, or Exchange/Answering Services	Must inform the member that the provider will call back within 30 minutes.
Life-Threatening Situation	Automated system must provide emergency **911** instructions, such as: • "Hang up and dial **911** or go to the nearest emergency room." Behavioral Health providers should include the number to the Santa Clara County Suicide and Crisis Hotline: • "Hang up and dial **911** or go to the nearest emergency room or call the crisis hotline at **1.855 278.4204**."
Urgent Need to Speak with a Provider	Automated system, office, or exchange/answering services must connect the member with an on-call provider or should direct the member on how to contact a provider after hours.

Exceptions to Time-Elapsed Standards

1. The waiting time for a particular appointment may be extended if the referring provider, or health professional, providing triage and screening services, and acting within the scope of practice, consistent with professionally recognized standards of practice, has determined and noted in the medical record that a longer waiting time will not have a detrimental impact on the health of the member.

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2. Preventive care services and periodic follow-up care, including standing referrals for chronic conditions, periodic office visits for pregnancy, cardiac or mental health conditions, laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating health care provider acting within the scope of practice.

3. Compliance with primary care time-elapsed standards can be made through an advanced access scheduling system, which is designed to improve patient access to care by eliminating barriers to such care.

Triage and Screening Services

A provider's triage and screening services offered by telephone must be provided in the following manner:

1. 24 hours per day, seven days a week by a qualified, licensed health professional.

2. Ensure triage and screening services are provided in a timely manner appropriate to the member's condition.

3. The wait time for triage and screening services does not exceed 30 minutes.

4. Provide a procedure which includes during and after business hours, a telephone answering machine, or answering service, and/or office staff that will inform the caller regarding the following:

   a. Wait time for a return telephone call, which shall not exceed 30 minutes;

   b. Instructions regarding obtaining urgent or emergency care, including, when applicable, how to contact another provider who has agreed to provide on-call coverage; and

   c. In no case shall unlicensed staff use a member's answers to questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of a member or determine when a member needs to be seen by a licensed medical professional.

Note: Clinical advice may only be provided by appropriately qualified, licensed health professionals, acting within the scope of their licensure, which includes physicians, physiciaants, nurse practitioners and registered nurses.

Nurse Advice Line

VHP members have access to a 24-hours-a-day, seven-days-a-week, 365-days-a-year Nurse Advice Line. The Nurse Advice Line is available at:

- **Commercial Employer Group: 1.866.682.9492**
- **Covered California and Individual & Family Plan: 1.855.348.9119**

Timely Access Monitoring

VHP regularly audits and monitors on an on-going basis, appointment and access standards per applicable rules, regulations, contracts, and guidance. All providers are responsible for responding to any appointment and/or access deficiencies identified by VHP's review methods, including the following:

- Appointment availability survey
- After-hours survey
- Provider satisfaction survey
- Access to care study
- Provider demographic survey

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CH 13:
Claims & Billing Submission

This Chapter Includes:

	Alert Alert draws attention to critical information that has changed this year.
	Contact Contact information on who to contact for assistance.
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CH 13: Claims & Billing Submission

Claims Processing

VHP recognizes the importance of prompt claims payments. VHP works hard to process clean claims timely and accurately. Understanding how the claims and billing processes works helps ensure that provider claims are processed timely and accurately. By law, VHP must pay or deny clean claims within 45 calendar days from the date of receipt.

> **Note:** A "clean claim" is a claim received by VHP for adjudication that has been completed and submitted without technical defect in its form, completion, or content. The claim must comply with standard coding guidelines and contain no missing information. In addition, a clean claim must include all substantiating documentation that VHP deems necessary for adjudication, and not require special processing or consideration, which would delay or prevent timely payment of the claim.

Introduction to Claims

VHP pays providers for medically necessary, covered services provided to members in accordance with VHP's authorization procedures. Covered services are reimbursed in accordance with the Centers for Medicare and Medicaid Services (CMS) billing and reimbursement guidelines, including but not limited to any applicable reductions and/or discounts (e.g., Hospital Acquired Conditions (HAC), Other Provider-Preventable Conditions (OPPCs) and multiple procedure reduction codes), which may be amended by CMS from time to time. A provider's payment is reimbursed using industry standard code auditing software, which incorporates CMS, American Medical Association (AMA), and other standard coding guidelines. VHP is not responsible for reimbursement of co-payments, deductibles, coinsurance, or for non-covered services rendered by a provider. VHP is also not responsible for payment for physical or behavioral health care services rendered that are limited or excluded by the member's benefit plan. The provider may seek payment from members for costs associated with services rendered that are limited or excluded by the member's benefit plan.

A claim is a request by a provider for reimbursement, which is submitted either electronically or by paper for services rendered. A claim will be paid or denied with an explanation for the denial. For each claim processed, a Remittance Advice (RA) is produced and sent to the "pay to" designated by the provider.

> **Note:** The following General Claims Submission Billing Tips can help you process claims quickly and efficiently.

Timely Filing

Providers must have their original claims (claims submitted for the first time) received by VHP no later than 90 calendar days for contracted providers unless otherwise specified in the provider agreement, and 180 calendar days for non-contracted providers from the date of service. When VHP is the secondary payer, the claim must be received no later than 90 calendar days for contracted providers and 180 calendar

days for non-contracted providers from the date of payment or denial by the primary payer. Claims submitted outside of these timeframes may be denied for untimely submission.

Preparing Complete and Accurate Claims

Claims are subject to the following requirements:

- Use of industry standard paper claim forms HCFA 1500 and UB-04

- HIPAA compliant ANSI X12 5010 837 (P&I) format for electronic claims and encounters

- Includes all diagnosis, procedure, modifier, place of service, revenue, type of admission and source of admission codes on the claim form that are valid for:

    – Date of service

    – Provider type

    – Bill type

    – Age/gender of the patient

- All diagnosis codes are completed to their highest level of specificity. Enter the principal diagnosis for which the claimed procedure applies as the first diagnosis on the claim form.

- Principal diagnosis billed on the claim reflects an allowed principal diagnosis as defined in the current volume of the ICD-10 CM. The principal diagnosis must be included on the claim in the primary or first position. Additional diagnoses should be included in the second, third and fourth positions, etc. on the claim form.

- Submission of a Present on Admission (POA) indicator for the principal and each additional diagnosis code submitted on the claim unless the code is exempt from POA reporting.

    a. The CMS POA indicator options include:

    – Y – Diagnosis was present at the time of inpatient admission.

    – N – Diagnosis was not present at the time of inpatient admission.

    – U – Documentation is insufficient to determine if the condition was present at the time of inpatient admission.

    – W – Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.

- Submission of a Hospital Acquired Condition (HAC) indicator to identify a medical condition or complication developed during a hospital stay, which was not present at admission. Presence of a HAC may affect reimbursement. Some examples of ICD-10 HAC codes are listed below:

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ICD-10 Codes for HAC

HAC 01: FOREIGN OBJECT RETAINED AFTER SURGERY SECONDARY DIAGNOSIS

- T81500A Unspecified complication of foreign body accidentally left in body following surgical operation, initial encounter

- T81510A Adhesions due to foreign body accidentally left in body following surgical operation, initial encounter

- T81520A Obstruction due to foreign body accidentally left in body following surgical operation, initial encounter

- T81530A Perforation due to foreign body accidentally left in body following surgical operation, initial encounter

- T81590A Other complications of foreign body accidentally left in body following surgical operation, initial encounter

- T8160XA Unspecified acute reaction to foreign substance accidentally left during a procedure, initial encounter

HAC 02: AIR EMBOLISM SECONDARY DIAGNOSIS

- T800XXA Air embolism following infusion, transfusion and therapeutic injection, initial encounter

HAC 03: BLOOD INCOMPATIBILITY SECONDARY DIAGNOSIS

- T8030XA ABO incompatibility reaction due to transfusion of blood or blood products, unspecified, initial encounter

- T80310A ABO incompatibility with acute hemolytic transfusion reaction, initial encounter

HAC 04: STAGE III and IV PRESSURE ULCERS SECONDARY DIAGNOSIS

- L89003 Pressure ulcer of unspecified elbow, stage 3

- L89103 Pressure ulcer of unspecified part of back, stage 3

- L89143 Pressure ulcer of left lower back, stage 3

- L89504 Pressure ulcer of unspecified ankle, stage 4

- L89614 Pressure ulcer of right heel, stage 4

- L89893 Pressure ulcer of other site, stage 3

HAC 05: FALLS AND TRAUMA SECONDARY DIAGNOSIS

- M9910 Subluxation complex (vertebral) of head region

- S020XXB Fracture of vault of skull, initial encounter for open fracture

- S02111A Type II occipital condyle fracture, initial encounter for closed fracture

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- S060X1A Concussion with loss of consciousness of 30 minutes or less, initial encounter
- S12111A Posterior displaced Type II dens fracture, initial encounter for closed fracture
- S12150A Other traumatic displaced spondylolisthesis of second cervical vertebra, initial encounter for closed fracture

Additional Considerations to Ensure Complete and Accurate Claims and Claims Payment

1. The member identification (ID) number is required on all claims. See <u>Chapter 3, "Enrollment and Eligibility"</u> for an image of the ID card and the location of the ID number.

2. Appropriate **prior** authorization must be obtained from VHP or its designee if services have been designated by VHP to require prior authorization. Further information regarding those services requiring prior authorization is available in <u>Chapter 17, "Utilization Management."</u>

3. Appropriate coordination of benefits (COB) information has been included with the submitted claim whenever the member has other coverage.

4. Rendering provider, address where service was rendered, signature, "remit to address", telephone number, NPI and federal TIN are all included.

5. Information regarding job-related, vehicular accident or other type of accident, if applicable and available.

6. Current National Drug Code (NDC) 11-digit number, NDC unit of measure (F2, GR, ML, UN) must be added and NDC units dispensed for all claims submitted with CMS J codes.

> **Note:** It is important to always verify that the member is eligible to receive covered services during the period in which such covered services will be rendered. Further information is available about VHP's eligibility verification processes in <u>Chapter 3, "Enrollment and Eligibility."</u>

Corrected Claims

A corrected claim is a resubmission of a previously submitted claim where the provider indicates a correction to the original claim. Providers must submit corrected claims using the electronic submission method or standard paper claim forms and include the appropriate resubmission codes on the claim. Corrected claims must include the original processed claim number. All accurate line items from the original claim submission must appear on the replacement claim along with the line items requiring a correction. In some cases, medical records may be required to justify corrections to diagnosis codes, diagnosis-related groups (DRGs), procedure codes, medication units, modifiers, or other modifications. Corrected claim submissions are subject to timely filing rules.

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> Note: Late charges or resubmission of late charges (resubmission code 5) will not be accepted. Submit a corrected claim using the valid resubmission code.

For Electronic Claims (EDI)

- **Electronic HCFA 1500 claims:**
  - EDI 837P data should be sent in the 2300 loop, segment CLM05 (with resubmission code) along with an additional loop in the 2300 loop, segment REF*F8* <u>with the original claim number for which the corrected claim is being submitted.</u>

- **Electronic UB-04 claims:**
  - EDI 837I data should be sent in the 2300 loop, segment CLM05 (with resubmission code) 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.

For Paper Claims

Note: Paper claims should only be submitted when additional documentation is attached to a claim. The preferred method of corrected claims submission is electronic.

- **CMS-1500 claims should be submitted with the appropriate resubmission code in Box 22 of the paper claim, and with the original claim number of the corrected claim in the Original Ref. No. section (see below).**

- **UB-04 claims** should be submitted with the appropriate resubmission code in the third digit of the bill type with:
  - The original claim number in **Box 64** of the corrected paper claim (see below)

Box 64

```
64 DOCUMENT CONTROL NUMBER
```

Resubmission Codes
- 1 - Original (initial claim)
- 7 - Replacement (replacement of prior claim)
- 8 - Void (void/cancel of prior claim)

Claim and Encounter Submissions
You must submit a claim or encounter for your services, including capitated services, regardless of whether you have collected the copayment, deductible or coinsurance from the member.

Electronic Submission of Claims and Encounters
Electronic data interchange (EDI) allows for faster, more efficient, and cost-effective claim submission for providers. The benefits include:
- Faster transaction time (time between submission and payment)
- No postage required
- Reduction of overhead and administrative costs
- Increased accuracy of data and efficient information delivery
- Clearinghouse acknowledges receipt of provider's claims

The same requirements for paper claims (e.g., timely filing, etc.) apply to EDI claims submissions. Claims not submitted with all the correct data fields may be rejected or denied.

Providers are encouraged to participate in VHP's EDI claims submission process. VHP has the capability to receive an ANSI X12N 837 professional and institutional claim or encounter transaction. In addition, VHP has the capability to generate an ANSI X12 835 electronic RA.

VHP's EDI claims clearinghouse, Utah Health Information Network (UHIN), has a portal known as the MYUHIN Claims Tool that allows providers to submit claims electronically, as well as view electronic

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RAs. To access MYUHIN, providers must first request EDI enrollment for 837P and 835. To request EDI enrollment for 837P and 835, please contact the Provider Relations Department at **1.408.885.2221**.

To utilize the MYUHIN Claims Tool:

- Go to the UHIN website (**www.uhin.org**) and click "Get Started."

- Complete and submit the Contract Sales Form.

- Under "What type of services are you interested in," select "Clearinghouse."

- In the box displayed, enter the average monthly transaction volume.

- In the additional comments section, enter "I want to submit professional claims to Valley Health Plan."

- Once submitted, UHIN will reach out to providers within one (1) business day to gather any additional information needed and to send out the VHP contract and enrollment form.

For more information on electronic claims filing, contact VHP's Provider Relations Department at **1.408.885.2221**.

EDI Flow Description

To send claims electronically to VHP, EDI claims must first be forwarded to VHP's clearinghouse, UHIN. This can be completed via a direct submission from the provider or through the provider's clearinghouse. In either case, EDI claims should be submitted to VHP's EDI clearinghouse:

UHIN

VHP's Trading Partner Number: HT007700-001
Utah Health's Customer Service Number: **1.877.693.3071**
VHP Payer ID: VHP01 (for all lines of business)

Claim 837 files sent to VHP's clearinghouse, UHIN, must first pass UHIN's standard format edits and VHP-specific edits prior to acceptance. Claim 837 files that do not pass these edits are invalid and will be rejected without being forwarded to VHP. If an 837 claim file is rejected, the claims must be corrected and resubmitted within the required timely filing deadline. It is important that providers review the claims acknowledgement and claims acceptance reports received from the UHIN to identify and re-submit these claims accurately.

Once claims are successfully filed at UHIN, you will receive a 999 acknowledgement from the provider's clearinghouse. You will also receive a 277CA response file with initial status of the claims from the provider's clearinghouse.

If you experience any problems with claims transmission or want to check the status of a claim, contact

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the provider's local clearinghouse representative. If the provider's clearinghouse is unable to resolve the issue, the provider may call VHP's clearinghouse, UHIN at **1.877.693.3071** for additional support.

Paper Claim Form Requirements

Although EDI submission of claims is preferred, VHP also accepts paper claim forms. VHP only accepts HCFA 1500 (version 02/12) and UB-04 forms. VHP does not supply claim forms to providers. Providers should purchase claim forms from a supplier of their choice.

VHP uses Optical Character Recognition (OCR) which allows paper claims to be scanned and data interpreted with minimal data entry. To facilitate the efficient and accurate paper claims processing, printed original red claim forms are required. Ensure that the criteria set forth below is consistently followed. Claims submitted that do not meet the requirements below will be returned, rejected, and/or denied.

1. No handwritten claims

2. Use only black ink

3. Do not use italics, red ink, stickers, rubber stamps

4. Do not use white correction fluid

5. Do not have data touch box edges

6. Ensure data is formatted and aligned correctly on the form

7. Provider and billing NPI for providers must be submitted

8. All data fields must be typed and legible

9. Claim forms must be signed and dated by the provider or a designee

Paper Claim Submission Exceptions:

1. Invoices

2. Proof of timely filing

3. Claim itemization

4. Medical records

Initial claims and corrected paper claims should be submitted to the following address:

> **Valley Health Plan**
> **P.O. Box 26160**
> **San Jose, CA 95159**

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National Provider Identification

The Health Insurance Portability and Accountability Act (HIPAA) requires health care professionals, hospitals, and other providers to obtain and use a standardized National Provider Identifier (NPI), which is a unique 10-digit identification number issued to health care providers by CMS. Providers are required to use an NPI as identification on electronic transactions and paper claim forms.

To avoid payment delays or denials, providers must submit a valid billing NPI, rendering NPI and relevant taxonomy code on all claims and encounters.

Assembly Bill (AB) 72

Passed into law in California on July 1, 2017, AB 72 provides protections for members from "surprise out-of-network billing."

This law applies to situations in which a VHP member receives services from an in-network, contracted health care facility (inpatient or outpatient hospital, laboratory, imaging center, etc.) and also receives covered services provided by an out-of-network, non-contracted or non-participating individual health care provider (surgeon, anesthesiologist, etc.).

A VHP member's cost share obligation is to pay no more than the "in-network cost-sharing amount" for services rendered at an in-network facility. That is, the member pays the non-contracted, out-of-network provider the same amount that they would have paid if the provider had been an in-network and contracted provider with VHP.

VHP notifies members and providers of the member's in-network cost-sharing amount. Cost-sharing arising from services provided by out-of-network providers is counted toward any deductible, coinsurance, and annual out-of-pocket maximums in the same manner as an in-network provider.

VHP reimburses for covered services from an out-of-network provider at VHP's Usual and Customary rate, filed and approved by DMHC. For more information on VHP's Usual and Customary rate for out-of-network providers, see **https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/Documents/CL-9_0-Non-Contracted-Provider-Reimbursement-Public.pdf**

Provider Preventable Conditions

Other Provider-Preventable Conditions (OPPC) are adverse medical conditions or complications (as defined by CMS, as amended) developed by a patient during a stay in a hospital or any health care setting. OPPCs are health care acquired conditions (HAC) when they occur in an acute inpatient hospital setting only, and OPPCs when they occur in any other health care setting.

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Acute inpatient hospital claims will be returned with no payment or denied if the POA indicator is coded incorrectly or missing.

Claims related to provider preventable conditions (PPC) may be denied and/or have their reimbursement reduced or modified.

Third Party Liability

The provider must make every attempt to identify other third-party coverage (e.g., health care coverage, worker's compensation, automobile, or other liability insurance) available to the member. The provider agrees to bill the appropriate insurance carrier for services. If VHP identifies other third-party coverage after the claim was paid, VHP has the right to recover the cost of the claim from the provider.

Coordination of Benefits

VHP coordinates benefits for members who are covered under two or more health insurers. When there is COB, VHP shares the cost of authorized services covered under VHP with the other insurer. Members may be able to receive up to 100 percent coverage. If services are not covered by VHP, the member may be covered through the secondary insurance.

VHP complies with federal and state regulations for COB and follows COB guidelines published by the National Association of Insurance Commissioners (NAIC).

When VHP is primary, the benefits of the plan are determined and applied to the cost of care without consideration of the secondary payor.

When VHP is secondary, VHP will coordinate coverage with the member's primary plan and may cover the cost of care up to, but not to exceed, the provider's full billed charges and in accordance with VHP's payment guidelines or provider's agreement with VHP.

When submitting a claim to VHP for any service partially paid or denied by the member's primary health insurer, a copy of the explanation of benefits (EOB) and RA or denial letter must accompany each claim for services that is covered by VHP's scope of benefits.

The EOB or denial letter must state the following:
- Name and address of insurance plan
- Recipient's (or member) name and policy number
- Statement of denial or payment amount
- Procedure or service rendered and denial date
- Date of service

- Provider information, including name, address, etc.

Claims Overpayments

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

If the provider contests VHP's notice of overpayment, the provider, within 30 business days of the receipt of the notice, must send written notice to VHP stating the basis upon which the provider believes that the claim was not overpaid. VHP will process the contested notice as a provider dispute (See Chapter 15, "Provider Disputes and Member Appeals and Grievances.")

If the provider does not contest VHP's notice of overpayment of a claim through VHP's provider dispute process, the provider must reimburse VHP within 30 busines days of the provider's receipt of the notice of overpayment.

VHP may offset an uncontested notice of overpayment against a provider's future claim submissions when:

- The provider does not reimburse VHP within the 30 business days of receipt of the notice; and
- VHP has a contract with the provider specifically authorizing VHP to offset an uncontested notice of overpayment of a claim from the provider's future claim submissions.

When there is an offset, VHP will provide a detailed written explanation to the provider, identifying the specific overpayment or offset payments that have been made against the current claim(s).

Provider Dispute Process

As required by California Assembly Bill AB 1455, VHP has established an expeditious, fair, and cost-effective dispute resolution mechanism that complies with DMHC requirements. Please reference Chapter 15, "Provider Disputes and Member Grievances and Appeals" for important details related to the dispute resolution procedure and process.

Reimbursement Policies

The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that the provider will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis.

Eligibility and benefit information are not a guarantee of payment or coverage in any specific amount. Actual reimbursement depends on many factors, such as compliance with clinical and administrative

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protocols, coding guidelines, date(s) of services rendered, and benefit plan terms and conditions.

Providers must follow proper billing and submission guidelines. Claims must include the use of industry standard, compliant codes for claims submitted. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes, and International Classification of Diseases (ICD-10-CM/ (ICD-10-PCS). The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, VHP may:
- Reject or deny the claim

- Reduce the payment of the claim

- Recover and/or recoup the amount of the claim payment

VHP reimbursement policies are developed based on nationally accepted industry standards and coding principles, including CMS. These policies may be superseded by mandates in the provider contract and/or state, federal or CMS requirements.

System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, VHP strives to minimize these variations.

Claim Edits and Industry Standard Correct Coding

Correct coding is required to properly process claims. VHP requires that all claims be coded in accordance with the HIPAA transaction code set as well as guidelines within each code set.

CPT and HCPCS Codes

Codes must be submitted in accordance with code-specific guidelines set forth in the current version of the American Medical Association (AMA) Current Procedural Terminology (CPT) and CMS' Healthcare Common Procedure Coding System (HCPCS).

Modifiers

Modifiers consist of two alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered and may be appended only if the clinical circumstances justify the use of the modifier(s). For a complete listing of modifiers and their appropriate use, consult the AMA CPT and HCPCS code books.

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ICD-10-CM/PCS Codes

VHP utilizes Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Disease (ICD), 10th Revision Procedure Coding System (ICD-10-PCS) as amended.

Type of Bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of billing for the particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC) Official UB-04 Data Specifications Manual (**www.nubc.org**).

Revenue Codes

Revenue codes are four-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official UB-04 Data Specifications Manual (**www.nubc.org**).

Diagnosis Related Group (DRG)

Facilities contracted to use a Diagnosis Related Group (DRG) reimbursement methodology must submit claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate claim payment. VHP utilizes the Medicare Severity-Diagnosis Related Group (MS-DRG) methodology for payment of claims based on a DRG for Commercial, IFP and Covered California lines of business.

VHP processes DRG claims through MS-DRG software. If the submitted DRG and system assigned DRG differ, VHP's assigned DRG will take precedence in the claims payment process. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the claim cannot be grouped due to insufficient information, it will be denied and returned to the provider for lack of sufficient information.

National Drug Code Number

The 11-digit National Drug Code Number (NDC) must be reported on all professional and outpatient claims when submitted on the CMS-1500 claim form, UB-04 or electronic equivalents. Claims submitted without the NDC number may be denied.

During the claims adjudication processes, VHP utilizes claims editing software that uses correct coding from industry standard sources, such as CMS, the AMA, CPT, HCPCS, ICD-10-CM, ICD-10 PC and VHP developed policies as applicable.

Claims editing software will be updated periodically, without notification, to reflect the addition of newly

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released/revised/deleted codes and their associated claim edits, including but not limited to National Correct Coding Initiative (NCCI) revisions and VHP payment policies (**www.cms.gov/Medicare/Coding/ NationalCorrectCodInitEd**).

Nationally Correct Coding Initiative Edits

CMS developed the NCCI for the purpose of maintaining consistent and correct coding and reducing inappropriate payment. The edits and policies do not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination.

NCCI includes three types of edits:
- NCCI Procedure-to-Procedure (PTP) edits
- Medically Unlikely Edits (MUEs)
- Add-on Code (AOC) edits

NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column One and Column Two HCPCS/CPT code. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the Column One code is eligible for payment but the Column Two code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported.

NCCI MUE edits prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances reportable by the same provider for the same beneficiary on the same date of service.

NCCIAOC edits consist of a listing of HCPCS and CPT add-on codes with their respective primary codes. An add-on code is eligible for payment if and only if one of its primary codes is also eligible for payment.

NCCI PTP edits are used by VHP's Claims Department to adjudicate claims for physician services, outpatient hospital services, and outpatient therapy services. These edits are not applied to facility claims for inpatient services. Physicians, hospitals, and other providers must code correctly even in the absence of NCCI edits.

Edit Updates and Changes

An NCCI edit is applicable to the period for which the edit is effective since the edit is based on coding instructions and practices in place during the edit's effective dates. NCCI PTP, MUE, or AOC edits may be revised for a variety of reasons and without notice to the provider.

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NCCI Edit Claims Denials

NCCI edits are auto-deny edits. CPT/HCPCS codes representing services denied based on NCCI PTP edits may not be billed to VHP members. A denial of services can be appealed to VHP's Appeals and Grievances department for review and/or redetermination.

Valley Health Plan
Appeals and Grievances Department
P.O. Box 28387
San Jose, CA 95159

VHP's Claim Auditing Software

VHP utilizes an automated solution to evaluate medical billing information and coding for accuracy. The automated solution compares submitted claims to many national standards like the AMA's CPT coding guidelines and NCCI edits.

The system evaluates the coding accuracy, not the medical necessity of the procedure(s). If the submitted coding does not meet current standards, the software provides the most appropriate coding or claim denial. The claim auditing software is designed to detect coding patterns, such as unbundling, integral procedures, and mutually exclusive procedures.

Coding criteria and services evaluated by the software include for example:
- Policies based on the CPT manual
- Policies based on health care coding standards
- Bundling/unbundling of procedures
- Global periods
- Multiple procedures performed the same day
- Appropriateness of assistants at surgery
- Proper use of modifiers

The software is utilized to:
1. Auto accept the code(s) as submitted
2. Deny codes based on NCCI and AMA guidelines
3. Prompt a review of the submitted code(s) to switch the codes to comply with generally accepted coding practices that are consistent with the AMA's CPT Manual and the CMS' HCPCS Level II Codes Manual
4. Seek additional information from the provider's office because there is inconsistent information on the claim

Payment/denial codes

The payment/denial codes that you may see referenced on a remittance advice are included below. If you have questions on a claim that has been affected by the editing, please contact Claims Customer Service at **1.408.885.4563**.

Code	Short Description	Long Description
AAS	Assistant at Surgery	The auditing software performs assistant surgeon auditing on procedures submitted with modifier AS.
AGE	Age	An age conflict occurs when a provider assigns an age-specific procedure to a member whose age is outside of the designated age range. Age edits include auditing for the following categories, as defined in the Medicare Code Editor (MCE): • Neonate procedure – age should be 0 to 30 days • Pediatric procedure – age should be 31 days to 17 years • Maternity procedure – age should be 12 to 55 years • Adult procedure – age should be over 14 years.
AST	Assistant Surgeon	The auditing software performs assistant surgeon auditing on procedures submitted with modifiers -80, -81, or -82.
CCI	CCI Incidental	CCI Incidental edits consist of those edits referenced as the CMS Column1/Column 2 edits, formerly the comprehensive/component edits.
CCM	CCI Mutually Exclusive	The auditing software provides CCI Incidental and CCI Mutually Exclusive auditing capability.
COS	Cosmetic	A number of surgical procedures may be performed without a medically indicated purpose and are considered cosmetic in nature.

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Code	Short Description	Long Description
DUP	Duplicate	Indicates duplicate procedures submitted with the same date of service.
EXP	Experimental	The auditing software allows health plans to identify procedures currently under investigation by their organization. Unlike other edits, an experimental procedure is one that is defined by the health plan based on its standard medical policy.
INC	Incidental	An incidental procedure is one that is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.
ME	Mutually Exclusive	Mutually exclusive edits consist of combinations of procedures that differ in technique or approach but lead to the same outcome. In some instances, the combination of procedures may be anatomically impossible. Procedures that represent overlapping services or accomplish the same result are considered mutually exclusive.
MOD	Modifier Override	Indicates a modifier overrode the auditing software edit.
MUE	Medically Unlikely Edit	The auditing software contains edits that describe procedure codes along with the number of times, or MUE limit, that the procedure can be performed per day on one submitted claim line.
OBS	Obsolete	An obsolete procedure is one that is no longer performed under prevailing medical standards. As such, a procedure designated as obsolete should be reviewed for medical necessity.
PRE	Pre-Op	The auditing software will produce a pre/post-operative edit denying Evaluation and Management (E&M) services that are reported with surgical procedures during their associated pre-operative periods.
PST	Post-Op	The auditing software will produce a pre/post-operative edit denying E&M services that are reported with surgical procedures during their associated post-operative periods.

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Code	Short Description	Long Description
REB	Re-bundle	Procedure unbundling occurs when two (2) or more procedure codes are used to report a service when a single, more comprehensive procedure code exists that more accurately represents the service performed by a provider.
UNL	Unlisted	Unlisted services or procedures are defined as those procedures or services performed by providers but not found in the current edition of CPT or HCPCS.
VIS	Medical Visit	The auditing software does not allow the separate reporting of most E&M services when a substantial diagnostic or therapeutic procedure is performed.

Review Schedules and Updates

VHP reserves the right to review and revise its policies periodically when necessary. Reimbursement policies go through a review for updates to state, federal or CMS contracts and/or requirements.

Additionally, updates may be made at any time if VHP is notified of a mandated change or due to a VHP business decision and do not require notice to the providers in advance of implementation.

Claims Auditing

To comply with state and federal requirements, VHP has a robust Fraud, Waste, and Abuse program to review submitted claims from all providers. This program is reviewed and updated annually to comply with applicable regulatory requirements. This program includes, but may not be limited to:

- Pre-payment and post-payment fraud, waste, and abuse detection and investigation including recovery when required
- Pre-payment and post-payment claim auditing
- Clinical code editing reviews
- Administrative overpayments reviews
- Predictive analytics
- Fraud risk assessment

See Chapter 21, "Regulatory & Compliance Requirements" for additional information about VHP's Fraud, Waste and Abuse program.

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CH 13: Claims & Billing Submission

CH 14:
Encounter Data

This Chapter Includes:

1. **What is an Encounter?**

2. **Encounter Data Requirements**

3. **Procedures for Filing Encounter Data Electronically**

⊘	**Alert** Alert draws attention to critical information that has changed this year.
📞	**Contact** Contact information on who to contact for assistance.
VHP	**Book Table of Contents** Click the purple VHP circle logo, located at the bottom left corner, to return to the main TOC.

What is an Encounter?

An encounter is equivalent to the submission of claims data information. It details the specific services provided to a member by a provider, often used when the provider is pre-paid or receives a capitated payment for the services provided to VHP members. For example, if you are the PCP for a VHP member and receive a monthly capitation amount for services, you must submit an encounter file (ANSI X12N 837) or an encounter (also referred to as a "proxy claim") on standard claims forms for each service provided. Since you receive a pre-payment in the form of capitation, the encounter or "proxy claim" is paid at zero dollars.

Encounter data is a very important source of information for administering and improving programs and instituting changes and improvements at VHP. VHP utilizes encounter data to evaluate all aspects of quality and utilization management, Healthcare Effectiveness Data and Information Set (HEDIS) reporting, capitation rates, and required data submission to federal and state agencies. VHP has contracted with UHIN, a data clearinghouse company, to assist providers with the proper formatting and timely and accurate submission of encounter data. For further information about VHP's clearinghouse, UHIN, see Chapter 13, "Claims and Billing Submission."

Encounter Data Requirements

All capitated providers contracted with VHP are required to submit encounter data for services provided under the capitated arrangement. Encounter data must be submitted, at minimum, monthly. Services must be coded accurately and comply with national standards.

Procedures for Filing Encounter Data Electronically

VHP requires that all providers file encounters electronically. VHP has the capability to receive an ANSI X12N 837 professional, institution or ancillary encounter transaction. In addition, VHP has the capability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP).

A single encounter is defined as all services performed by a provider on a given date of service for an individual member. The following guidelines are intended to assist providers with submission of complete encounter data:

- Reporting of services must be completed on a per member, per visit basis.
- Reporting of all services rendered by date must be submitted to VHP.
- All encounter data reporting is subject to, and must be in full compliance with, HIPAA and any other regulatory reporting requirements.
- All encounter data must be submitted in a HIPAA compliant 837 format (ANSI X12N 837).

CH 14: Encounter Data

CH 15:
Provider Disputes & Member Grievances

This Chapter Includes:

	Alert
!	Alert draws attention to critical information that has changed this year.
☎	**Contact** Contact information on who to contact for assistance.
VHP	**Book Table of Contents** Click the purple VHP circle logo, located at the bottom left corner, to return to the main TOC.

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CH 15: Provider Disputes & Member Grievances & Appeals

VHP is committed to ensuring that its providers and members can resolve issues through its grievance and appeals process. VHP does not discriminate against providers or members for filing a grievance or an appeal. Providers are prohibited from penalizing a member in any way for filing a grievance. Furthermore, VHP monitors its grievance and appeals process as part of its quality improvement program and is committed to resolving issues within established timeframes, referring specific cases for peer review when needed.

Section I: Provider Disputes
Provider Dispute Resolution Procedure and Process
It is the policy of VHP to establish an expeditious, fair, and efficient dispute resolution mechanism to process and resolve disputes. Per Assembly Bill 1455, a provider has up to 365 calendar days to file a dispute from the date of last action taken by VHP. A letter of acknowledgement will be sent via U.S. mail within 15 days of VHP receiving a completed provider dispute paper form. VHP will send a resolution letter within 45 business days.

> (!) Use the following link to download the Provider Dispute Form: **https://www.valleyhealthplan. org/sites/g/files/exjcpb771/files/Provider-Dispute-Form-Final.pdf**The Provider Dispute Form is also located in the **Appendix**.

Completed Provider Dispute Forms can be submitted to:

> **Valley Health Plan**
> **Provider Dispute Resolution**
> **P.O. Box 28387**
> **San Jose CA 95159**
> **Phone: 408.885.7380**

Dispute Resolution Mechanism
Each provider dispute must contain at least the following information and be submitted on the form referenced above:

1. Provider National Provider Number (NPI)
2. Provider Tax Identification Number (TIN)
3. Provider contact information, including complete provider name and mailing address
4. Member/patient name and member ID number
5. Member date of birth
6. Patient account number, if applicable
7. VHP claim number, date of service, original claim amount billed, and original claim amount paid
8. Dispute description, including any documentation supporting the dispute

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9. Contact information for the individual submitting the dispute on behalf of the provider, including telephone and fax numbers, and mailing and email addresses

Provider Dispute Form (Page 1)

VHP Provider Dispute Form
Claims, Medical, and Administrative Disputes
Phone: 1.408.885.7380

Valley Health Plan

Providers may complete this form to dispute a VHP claim denial or an authorization denial.

Date:

- Fields with an asterisk (*) are required in order for VHP to process.*
- Provider should specify and attach any additional information or documentation to support the description of the dispute.
- For multiple like disputes please use Multiple Like dispute form.
- If provider is appealing on behalf of the member, an AOR form is required.
- For reconsiderations or retro-authorization requests, please submit authorization request direct to:

Valley Health Plan Attention: Utilization Review Department
FAX: 408.885.4875 or VHP Contracted Providers may use on-line submission through Valley express

Provider Information:

*Provider NPI:	*Provider Tax ID:
*Provider Name:	
*Provider Address:	

Provider Type: ☐ MD ☐ Mental Health   ☐ Hospital   ☐ ASC   ☐ SNF

☐ DME ☐ Rehab   ☐ Home Health   ☐ Ambulance ☐ Other: _____

Dispute Type: ☐ Claims   ☐ Contract Dispute
• Underpayment/Overpayment/Timely Filing/EOB
☐ Appeal of Medical Necessity / Utilization Management Decision (*Authorization reference)
☐*Authorization Number ☐Other:

Claim Information: _____

*Patient Name:	*Date of Birth:
*Member ID #:	Patient Account Number:
*VHP Claim #:	*Date of Service:
*Original Claim Amount Billed:	Original Claim Amount Paid:

*Dispute Description:

Attachments: ☐ Medical Records   ☐ Authorization / Referral   ☐ COB / EOB
☐ Proof of Timely Filing   ☐ Proof of Eligibility   ☐ AOR
☐ Other: ☐ Invoice / Bill

Expected Outcome:

Contact Information:

*Contact Name: _____ Title: _____ Phone Number: _____
*Signature: _____ Date: _____ *Fax Number: _____
*Mailing Address: _____
*Email _____

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Provider Dispute Form (Page 2) - Multiple "Like" Claims

In addition to the Provider Dispute Form above, submit the following form in those instances where multiple claims involving different members have been denied for the same reason.

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Provider Dispute Form

For Use with Multiple "LIKE" Claims
Phone: 1.408.885.7380

Date: _____

Multiple "LIKE" claims are for the same provider and dispute type but different members. Fields with an asterisk (*) are required. If filing multiple "LIKE" claims please complete Provider Dispute Form and submit online.

*Provider Name: _____   NPI Number: _____

*Provider Address: _____

	*Patient Name		*Date of Birth	*Health Plan ID Number	*Original Claim Number	*Date of Service	*Original Claim Amount Billed	Original Claim Amount Paid
	Last	First						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

*Contact Name: _____ Title: _____ Phone Number: _____

*Signature: _____ Date: _____ *Fax Number: _____

*Mailing Address: _____

*Email: _____

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Dispute Resolution

Provider disputes that do not include all required information may be returned for additional information. VHP will identify, in writing, the missing information necessary to review and resolve the provider dispute. The provider must resubmit the amended dispute along with the requested additional information within 30 calendar days. Failure to submit additional information within the required timeframe will result in denial of the dispute by VHP.

If the provider initiates a dispute of a claim or requests reimbursement of an underpaid claim, the provider

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must submit a Provider Dispute Form with all required elements.

If the provider's dispute or amended dispute involves a claim which is determined in whole or in part in favor of the provider, VHP will pay for any outstanding monies and interest due, and any penalties due as required by law or regulation, within five (5) business days of the issuance of a written determination.

A provider will be considered a "contracted provider" for those VHP lines of business or products in which the provider is participating as a network provider. Therefore, any claims for services provided to a member for which the provider is not "in-network" shall be subject to all applicable VHP policies and state or federal laws or regulations that apply to non-contracted providers. VHP shall utilize the provider's NPI specified in the provider's agreement with VHP to determine contract status for any lines of business or products offered by VHP.

No Punitive Action Against a Provider

VHP does not discriminate against a provider who files a contracted provider dispute or a non-contracted provider dispute. Furthermore, VHP does not take punitive action against a provider who files an appeal/grievance on behalf of a member, requests an expedited appeal/grievance on behalf of a member, or supports a member's appeal/grievance or request for an expedited appeal/grievance.

Resolution via Corrected Claim

If a claim is denied for missing information as indicated on the Remittance Advice (RA), VHP recommends that the provider not file a dispute, but rather submit a corrected claim with the missing information to VHP's Claims Department for processing and adjudication. Submission of a corrected claim does not waive the provider's right to submit a dispute.

Submit corrected claims with documentation to:

> **Valley Health Plan Commercial/ Covered California**
> **P.O. Box 26160**
> **San Jose, CA 95159**

A full replacement claim is required for corrected claims as all prior information and attachments are "replaced" with the new submission. All accurate line items from the original submission must appear on the replacement claim along with the line items requiring correction to avoid unintended refund or overpayment requests. To justify corrections to diagnosis codes, DRGs, procedure codes, medication units, modifiers or other "clinical modifications" medical records are required. For more information, see Chapter 14, "Claims and Billing Submission."

Section II: Member Appeals and Grievances
Member Grievance Procedure and Process

VHP maintains a procedure for the receipt and prompt internal resolution of all grievances and appeals. This process is based upon the following definitions of a grievance and an appeal:

- A *grievance* is any expression of dissatisfaction to VHP by a provider or member about any matter other than a Notice of Action (NOA). A NOA informs the member of their rights to challenge a decision regarding health care services.

- An *appeal* is a formal request for VHP to change an authorization decision upheld by VHP through the grievance and appeal process.

How to File a Grievance or Appeal

VHP members have the right to file a grievance regarding, for example, concerns related to quality of care, quality of service, and access to care. VHP members may appeal any delayed, modified, or denied medical service or claim. VHP allows members to file grievances within 180 calendar days following any incident or action that is the subject of the member's dissatisfaction.

Members may file an appeal or a grievance with VHP by one of the below methods:

1. Contact Member Services at 888.421.8444 (for TTY, contact California Relay by dialing **711** or **1.800.735.2929**)

2. **Submit an online grievance form in English, Spanish or Vietnamese through VHP's website: https://www.valleyhealthplan.org/sites/m/mm/Grievances/Pages/GrievanceForm.aspx**; or

3. Mail a Grievance Form to Member Services at 2480 N. First Street, Suite 160, San Jose, CA 95131. The Grievance Form is included in the **Appendix**.

A provider, with the member's written consent, may file a grievance or appeal on behalf of a VHP member. For the provider to act as the member's representative, the member and provider must complete the Authorized Representative Form and submit the completed PRF along with the grievance or appeal. **The ARF form can be found online: https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/P-AuthorizedRepresentativeForm-EN-2020-PR.pdf.** The Authorized Representative Form may also be found in the **Appendix**.

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Standard Review Process

VHP will acknowledge routine grievances within five (5) calendar days and resolve grievances within 30 calendar days.

Expedited Review Process

A member has the right to an expedited decision when the routine decision-making process for an appeal/grievance might pose an imminent or serious threat to health, including, but not limited to severe pain, potential loss of life, limb, or major bodily function. VHP will evaluate the member or provider's request and the member's medical condition to determine if it qualifies for an expedited decision. Expedited reviews will be processed as soon as possible to accommodate the member's condition, but not to exceed 72 hours from VHP's initial receipt of the appeal or grievance.

Department of Managed Health Care (DMHC)

Members have the right to contact the DMHC with a grievance, as well as the right to submit a request for an expedited grievance to DMHC. The member can submit this request when challenging a decision to deny, delay or modify health care services on the grounds of medical necessity for cases involving an imminent and serious threat to health. This includes, but is not limited to, severe pain or potential loss of life, limb, or major bodily function.

DMHC will resolve an expedited grievance within 72 hours and may contact VHP 24 hours per day, seven (7) days per week. Members can contact DMHC at **1.888.466.2219** (for TTY, contact the California Relay by dialing **711** or **1.877.688.9891**). Members also can access the DMHC website (**www.hmohelp.ca.gov**) for complaint forms, Independent Medical Review (IMR) application forms, and online instructions on how to file a grievance.

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CH 16:
Pharmacy Services

This Chapter Includes:

	Alert
!	Alert draws attention to critical information that has changed this year.
Contact	Contact information on who to contact for assistance.
Book Table of Contents	Click the purple VHP circle logo, located at the bottom left corner, to return to the main TOC.

VHP covers medications and pharmaceutical supplies listed in the VHP formulary that are considered VHP-preferred prescription drugs in accordance with the member's Evidence of Coverage (EOC). VHP contracts with Navitus Health Solutions (Navitus), a pharmacy benefit management (PBM) company, to administer the prescription drug benefit.

Navitus processes claims, prior authorization requests, and provides customer service on behalf of VHP to VHP members. Navitus Customer Care is available to answer providers' pharmacy benefit questions at **1.866.333.2757**, 24 hours per day, seven days per week (except Thanksgiving Day and Christmas Day).

Drug Formulary

VHP's drug formulary is the list of prescription drugs that has been reviewed, selected, and approved by VHP and its Pharmacy and Therapeutics Committee (P&T) in accordance with national standards of care. The formulary is updated monthly and posted on the following websites:

> **VHP:** **www.valleyhealthplan.org/sites/p/fr/Pages/Pharmacy/Formulary.aspx**
>
> **Navitus: https://prescribers.navitus.com/vhp**

The formulary includes both brand name and generic equivalent drugs, all of which are approved by the Food and Drug Administration (FDA). Generic drugs are identical or bioequivalent to a brand name drug in dosage, form, safety, strength, route of administration, quality, performance characteristics, and intended use.

Providers should refer to the formulary to determine coverage of smoking cessation, over the counter (OTC) medications, and other covered medications.

VHP covers formulary medication and supplies prescribed by licensed providers within the scope of their practice. VHP providers are essential to the appropriate use of pharmaceuticals. The prescribing provider's responsibilities include:

- Selecting the best, most economical drug, and dosage form to treat the member's condition;
- Ensuring each member clearly understands the drug's use, the correct dose and possible side effects;
- Reviewing and reconciling the member's medication list, including dosages, drug interactions, duplicate therapy, and non-adherence to prescribed therapies;
- Discontinuing ineffective drugs; and
- Carefully monitoring therapeutic drug levels, as necessary.

Note: Certain medications prescribed by dentists and optometrists within their scope of practice may be covered on the formulary. Dentists may only prescribe for antibiotics and pain medications. Optometrists may only prescribe for ophthalmic agents.

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The following abbreviations may be used in VHP's drug formulary:

ABBREVIATION	DESCRIPTION
¢	Tablet Splitting Program
BRANDS	Brand drugs are represented in uppercase letters
EXC	Plan Exclusion
GENERIC	Generic drugs are represented in lowercase letters
INF	Infertility
LD	Limited Distribution
M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program
NC	Not Covered
OTC	Over the Counter
PA	Prior Authorization
PAD	Provider Administered Drug
QL	Quantity Limit
RS	Restricted to Specialist
SF	Limited to two 15-day fills per month for first three (3) months
SMKG	Smoking Cessation
ST	Step Therapy
VAC	Vaccine Program

VHP's Pharmacy and Therapeutics (P & T) Committee

VHP's P&T Committee oversees the pharmacy benefit including the outpatient prescription formulary system ensuring that it is based on safe, appropriate, and cost-effective drug use. VHP's P&T Committee meets quarterly to develop, modify, and oversee which drugs will appear on VHP's drug formulary. The P&T Committee approves utilization management edits such as prior authorization (PA), step therapy (ST), quantity limitations (QLs), and specialty prescribing (SP). The committee members are providers and pharmacists from various specialties. The P&T Committee frequently consults with other subject matter experts for additional input.

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Providers can make recommendations for additions to or removal of pharmaceuticals from the formulary to the P&T Coordinator by completing the VHP Formulary Drug Review Request Form, which is available in the Appendix. Providers can submit this request form to at Pharmacy Services via email at **vhppharmacy@vhp.sccgov.org** or by fax at **1.408.943.8235**. For questions regarding the formulary, please contact Pharmacy Services at **1.408.793.6765**.

In addition to the formulary, when a provider logs into the Navitus Provider Portal with their NPI and selects Valley Health Plan, the provider will be able to access information about VHP's prior authorization criteria.

Type	Name	Drug Name	Size
🗎	*EXCEPTION TO COVERAGE (ETC) - Criteria Only		25 KB
🗎	*PRESCRIPTION DRUG PRIOR AUTH REQUEST FORM 61-211 *Mandatory Universal PA Form - State of CA*	PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM	110 KB
🗎	ACNE AGENTS - Criteria Only	adapalene 0.1% cream, adapalene 0.1% gel, adapalene 0.1% lotion, DIFFERIN OTC GEL, DIFFERIN LOTION, tretinoin cream, tretinoin gel	22 KB
🗎	ACTEMRA SC - Criteria Only	tocilizumab SC (ACTEMRA SC)	53 KB
🗎	AFINITOR - Criteria Only	everolimus (AFINITOR / AFINITOR DISPERZ)	25 KB

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Tiered Copay Program

VHP has several different tiered copay programs for Commercial Employer Group, Covered California, and the Individual & Family Plan (IFP). Members and providers have a wide range of drug product choices when a prescription is written. It is important for the member and provider to work together to determine which drug is most appropriate.

Commercial Employer Group

- Tier 0: Birth control, healthcare reform drugs (as defined below), vaccines, and provider administered drugs (PAD)

- Tier 1: Generic drugs

- Tier 2: Brand name drugs

- Tier M: Drugs that must be submitted under the medical benefit (see "Chapter 13, Claims and Billing Submission" and "Chapter 17, Utilization Management")

Covered California and Individual & Family Plan

- **Tier 0** – Birth control, healthcare reform drugs, and vaccines

- **Tier 1** – Most generic drugs and low-cost preferred brands

- **Tier 2** – Non-preferred generic drugs, preferred brand name drugs, and any other drugs recommended by the P&T Committee based on drug safety, efficacy, and cost

- **Tier 3** – Non-preferred brand name drugs; drugs that are recommended by the P&T Committee based on drug safety, efficacy, and cost; or drugs that generally have preferred and often less costly therapeutic alternatives at a lower tier

- **Tier 4** – Drugs that are biologics and drugs that the FDA or drug manufacturer require to be distributed through specialty pharmacies; drugs that require the member to have special training or clinical monitoring; or drugs that cost VHP more than $600 net of rebates for a one-month supply

- **Tier M** – Drugs that need to be submitted under the medical benefit

Healthcare reform drugs: Include but are not limited to the following: prenatal vitamins, fluoride preparations, aspirin 81mg-325mg generic single ingredient products only, iron preparations (supplements), generic immediate release single ingredient products, tobacco cessation products, tamoxifen/raloxifene, statins (lower strengths), bowel preparation, medications recommended by the United States Preventive Services Task Force (USPSTF), and Grade A or Grade B recommendations (i.e., vitamin D, folic acid).

Oral anticancer medication: The total amount of copayments and coinsurance the member is required

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to pay shall not exceed $250 after the deductible has been met for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication covered under the formulary.

> ⚠ Tiers are subject to change throughout the year. To find the most up-to-date formulary status and utilization management edits for a specific drug, visit the VHP website at **https://www.valleyhealthplan.org/sites/p/fr/Pages/Pharmacy/Formulary.aspx**.

VHP Pharmacy Benefits and Authorization

VHP uses a formulary developed by VHP's P&T Committee. The primary purpose of the formulary is to promote efficacious and cost-effective pharmacotherapy. In most instances, medications will be dispensed by the pharmacy without the need for any intervention. However, in some instances the pharmacy will require additional information from the prescribing provider to dispense the medication and receive payment.

The formulary is dynamic and the most current formulary and/or formulary updates can be accessed through VHP's website at: **www.valleyhealthplan.org/sites/p/fr/Pages/Pharmacy/Formulary.aspx**

If you subscribe to Surescripts, the e-prescribing software through your electronic health record (EHR), you can access the formulary and electronically send prescriptions for members directly to VHP network pharmacies. VHP asks that providers follow the formulary when prescribing for members to treat and manage medical and behavioral conditions.

There may be instances when a medication, previously approved for coverage on the formulary, is no longer covered because VHP has changed the benefit to cover an alternative drug that is medically appropriate, safe, and effective for the member. VHP encourages providers to follow VHP's coverage benefit. If you would like to continue to treat the member's condition with the previously approved medication, continued coverage may be approved when appropriate clinical documentation is provided to VHP.

Vacation Supply

VHP allows for a 30-day vacation supply. A member may request a vacation supply at a contracted VHP pharmacy (retail network pharmacy). The retail network pharmacy will contact Navitus to request a vacation supply override for the member. For lost, stolen, or misplaced medications, the member may be held financially responsible.

Drugs Covered Under the Medical Benefit

Drugs that are required to be given in a provider's office or an outpatient infusion center may be covered under the member's medical benefit or under the pharmacy benefit. Refer to the formulary for

up-to-date coverage information. In those instances when a drug will be administered at the provider's office or outpatient infusion center and is covered under the pharmacy benefit, the drug can be obtained through the Mandatory Specialty Pharmacy and sent directly to the provider's office or outpatient infusion center, see below for more information about Mandatory Specialty Pharmacies.

Mandatory Specialty Pharmacy Drugs

Certain specialty formulary drugs are classified as Mandatory Specialty Pharmacy (MSP) drugs by the P&T Committee and are provided ***exclusively*** through the Santa Clara Valley Medical Center (SCVMC) Specialty Pharmacy or Lumicera Specialty Pharmacy (Lumicera). MSP drugs may require specialized delivery and administration and are often for serious chronic conditions that involve complex care issues that need to be managed.

These specialty pharmacies have dedicated teams of pharmacists, specialty technicians, patient care coordinators, and/or nurses available to answer questions. The SCVMC Specialty Pharmacy and Lumicera teams work with providers to coordinate patient care for optimal member outcomes.

Members may receive MSP drugs by:
1. picking MSP drugs up at the SCVMC Specialty Pharmacy;
2. picking MSP drugs up at any Valley Health Center Clinic location; or
3. having MSP drugs mailed to a home, office, or other location.

For the addresses where MSP medications can be picked up, contact the SCVMC Specialty Pharmacy at **1.833.543.0744**.

At Lumicera, MSP drugs are delivered through a mandatory mail order program, using free and discreet delivery to the member's home, office, or other location. For more information or questions, contact Lumicera at **1.855.847.3554**.

Specialty drugs are available for a maximum of a 30-day supply. For a list of MSP drugs, please visit the VHP website at: (**https://www.valleyhealthplan.org/sites/p/fr/Pages/Pharmacy/Formulary.aspx**) or contact Navitus Customer Care at **1.866.333.2757**.

Drugs covered under the medical benefit will follow guidelines approved by VHP. All prior authorization requests must be submitted through Valley Express, VHP's Utilization Management Authorization System. (see Chapter 17, "Utilization Management").

Prescription Drug Prior Authorization and Exception to Coverage

> ⚠ When a drug is on the formulary and requires prior authorization (PA) or is not on the formulary, you must complete a Prescription Drug Prior Authorization or Step Therapy Exception Request Form (included in the **Appendix**) for the member, with information that supports the request for a drug, and submit it to Navitus via fax at **1.855.878.9210**.

The form will be reviewed by a pharmacist, physician, or the provider's designee based on established clinical criteria and/or medical necessity. A decision is made within ***72 hours for non-urgent*** requests and within ***24 hours if exigent*** circumstances exist.

An "exigent circumstance" exists when a member is suffering from a health condition that may seriously jeopardize the member's life, health, or ability to regain maximum function or when a member is undergoing a current course of treatment using a non-formulary drug. The member's provider will receive communication reflecting the decision via the fax number provided on the Prescription Drug Prior Authorization or Step Therapy Exception Request Form, while the member will be mailed a letter to the address on record that reflects the decision.

A list of formulary drugs requiring PA is available on the VHP website (**https://www.valleyhealthplan. org/sites/p/fr/Pages/Pharmacy/Formulary.aspx**) or can be obtained by contacting Navitus Customer Care at **1.866.333.2757**. The clinical criteria for the formulary drugs with PA are available on the Navitus Provider Portal (**https://prescribers.navitus.com/**) or can be obtained by contacting Navitus Customer Care at **1.866.333.2757**.

How to Dispute Adverse Determinations

A prescribing provider may request that the original exception request and subsequent denial be reviewed by an independent review organization. If the original request was a ***standard*** exception request, VHP will decide to authorize an external exception request by an independent review organization no later than ***72 hours*** following the receipt of the request. If the original request was an ***expedited*** exception request, VHP will make a determination to authorize an external exception request by an independent review organization no later than ***24 hours*** following the receipt of the request (see Chapter 15, "Provider Disputes and Member Appeals or Grievances").

Step Therapy

Selected formulary drugs require step therapy (ST), which means that a member must first try an alternative, clinically equivalent formulary drug. The P&T Committee selects all drugs required for ST. There may be exceptions made to ST when it is medically necessary for a member to receive medications without first trying an alternative drug. In these instances, the prescribing provider must complete and

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submit a Prescription Drug Prior Authorization or Step Therapy Exception Request Form to Navitus via fax at **1.855.878.9210**. The list of formulary drugs with ST is frequently reviewed and may be changed as appropriate by the P&T Committee. A list of the formulary drugs with ST is available on the VHP website (**https://www.valleyhealthplan.org/sites/p/fr/Pages/Pharmacy/Formulary.aspx**) or can be obtained by contacting Navitus Customer Care at **1.866.333.2757**.

Quantity Limitation Program

To address potential safety and utilization concerns, VHP has placed quantity limitations (QL) on some prescription drugs. Members are covered for up to the amount posted in the VHP formulary based on recognized standards of care and FDA-approved dosing guidelines. If you believe it is necessary to prescribe more than the QL amount posted on the formulary, you must submit a Prescription Drug Prior Authorization or Step Therapy Exception Request Form to Navitus via fax at **1.855.878.9210**. A list of the formulary drugs with QLs is available on the VHP website (**https://www.valleyhealthplan.org/sites/p/fr/Pages/Pharmacy/Formulary.aspx**) or can be obtained by contacting Navitus Customer Care at **1.866.333.2757**.

Dispense as Written Prescriptions

When available, VHP exclusively covers generic formulations of brand name drugs. If a member requests the brand version of a covered medication that has a generic or if the prescribing provider requests the brand version and marks "Dispense as Written" (DAW) on the prescription and initials it, the member will be responsible for any applicable copay and any cost difference between the generic drug and brand drug. If the brand version of a drug is being requested because of a perceived quality issue with the generic version, the provider must submit a completed FDA MedWatch report to the FDA at **https://www.accessdata.fda.gov/scripts/medwatch/**. This requirement alerts the FDA to any potential quality issues with the generic product. If you would like to request a DAW waiver for a member, you must complete and submit a Prescription Drug Prior Authorization or Step Therapy Exception Request Form, as well as provide attestation that the FDA MedWatch report has been submitted to Navitus via fax at **1.855.878.9210**.

Mail Order Pharmacy Prescription Drug Program

VHP contracts with Costco to administer the Mail Order Pharmacy Prescription Drug Program. If a member is prescribed a maintenance drug for a chronic condition, use of the Costco Mail Order Pharmacy Prescription Drug Program is recommended.

Providers may send a new prescription to or renew a prescription with Costco using one of the following methods:

1. Telephone: **1.800.607.6861**

2. Fax: **1.888.545.4615**

3. E-Prescription: NCPDP: 5633753

4. Mail: 215 Deininger Circle, Corona, CA 92880

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Prescriptions must include the following information (no additional form is required):

- Member name

- Date of birth

- Phone number

- Shipping address

Federal Drug Administration Recalls

Recalls are classified into a numerical designation (I, II, or III) by the FDA to indicate the relative degree of health hazard(s) presented by the product being recalled.

- Class I – a situation in which there is a reasonable probability that the use of or exposure to a violative product will cause serious adverse health consequences or death.

- Class II – a situation in which the use of or exposure to a violative product may cause temporary or medically reversible adverse health consequences, where the probability of serious adverse health consequences is remote.

- Class III – a situation in which use of or exposure to a violative product is not likely to cause adverse health consequences.

A Class I recall is a mandatory drug withdrawal required by the FDA and notifications are provided through recall postings from the FDA. If a member is on a drug that is part of a Class I recall, Navitus will notify both the provider and member within two business days after Navitus receives notification. If additional information is required regarding a recent recall, contact Navitus Customer Care at **1.866.333.2757 (toll-free)** or visit the VHP website at **(https://www.valleyhealthplan.org/sites/p/fr/Pages/Pharmacy/Formulary.aspx)**.

A Class II recall is a voluntary drug withdrawal from the market for safety reasons by the drug manufacturer. If a member is taking a drug that is part of a Class II recall, Navitus will notify the provider and member within 30 calendar days of the FDA notification.

Provider Administered Drugs

Provider administered drugs (PADs) are covered through the medical benefit. Some PADs can be covered through the pharmacy benefit; refer to the VHP formulary for additional information.

Vaccinations and Immunizations

Vaccinations and immunizations are covered by VHP when administered through a VHP contracted provider or pharmacy. If you are unable to offer a vaccination or immunization, the member should

be referred to a VHP pharmacy for the vaccination and/or immunization. Covered vaccinations and immunizations, as well as any applicable restrictions, are reflected on the VHP formulary. If additional information is required:

- Visit the VHP website (**https://www.valleyhealthplan.org/sites/p/fr/Pages/Pharmacy/ Formulary.aspx**);
- Contact Navitus Customer Care at **1.866.333.2757 (toll-free)**; or
- Contact Provider Relations, Monday to Friday, 9:00 AM to 5:00 PM, at **1.408.885.2221, Option 2.**

Contracted Network Pharmacies

The network of VHP pharmacies is subject to change. For the most current list of pharmacy locations and to confirm the pharmacies available in a member's network, visit the VHP website (**https://www. valleyhealthplan.org/sites/p/fr/Pages/Pharmacy/Formulary.aspx**) or contact Navitus Customer Care at **1.866.333.2757**.

National Drug Codes

VHP requires that National Drug Codes (NDC) be submitted on claim forms when billing for drugs administered by physicians, outpatient hospitals, or dialysis centers. Additionally, NDCs must be reported on claim forms when billing VHP as the secondary or tertiary payer. An NDC is a unique 10-digit or 11-digit, three-segment number and universal product identifier for a human drug in the United States.

The three segments of an NDC identify the:
- Labeler
- Product
- Commercial package size

The first set of numbers in the NDC identifies the labeler (manufacturer, re-packager, or distributer); the second set of numbers identifies the specific strength, dosage form (capsule, tablet, liquid), and formulation of a drug for a specific company; and the third set identifies package sizes and types. The labeler number is assigned by the FDA, while the product and package numbers are assigned by the company.

An NDC can be found on the drug product labeling (package insert) as well as the package/container itself. Hyphens (-) separate the number into three segments. Although an NDC on a drug container may have fewer than 11 digits, an 11-digit number must be entered on the claim form. An NDC entered on the claim must have *five digits in the first segment, four digits in the second segment, and two digits in the last segment.*

Placeholder zeros must be entered on the claim wherever digits are needed to complete a segment.

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The NDC reported must be the actual NDC on the package or container from which the medication was administered.

The following qualifiers are to be used when reporting an NDC:
- F2 International Unit
- GR Gram
- ME Milligram
- ML Milliliter
- UN Unit

Clinical Programs

The Navitus claim payment system scans every claim during adjudication for potential safety issues. Generally, electronic alerts are issued for the following concurrent drug utilization review (CDUR) edit categories:
- Drug-drug interaction
- Underuse
- Drug-age conflict
- High and low dosage warning
- High and low duration warning
- Therapeutic duplication
- Acetaminophen high dose (APAP)
- Morphine equivalent dose (MED)
- Opioid naïve member, which means that the member has not used opioids for more than seven consecutive days during the previous 30 days

When the claim triggers one of the above-mentioned electronic alerts, the pharmacy may contact the provider to clarify the claim prior to placing an override.

Retrospective Drug Utilization Review Safety

Retrospective drug utilization review (RDUR) programs focus on determining the appropriateness, necessity, quality, and reasonableness of medication therapies using retrospective claims analysis based on a predefined time period, when applicable.

RDUR programs are designed to promote good health and safety by encouraging member adherence to nationally recognized treatment standards through coordination of care, support, prevention, and

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education. If a member meets the established criteria for participation in any of the following programs, you will receive a notification letter from Navitus about the program, member, and medications. Common issues that may indicate the member meets the established criteria include:

- Morphine milligram equivalent (MME)
- Multi-prescriber
- Controlled substance monitoring
- Duplicate therapy
- Double threat
- Multi-prescription
- Expanded fraud, waste, and abuse

VHP expects its providers to review the member's profile. If the therapy is appropriate, no action is needed. If the therapy needs to be adjusted, the provider must discuss the adjustment with the member and contact the pharmacy to modify the prescription.

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CH 17:
Utilization Management

This Chapter Includes:

	Alert
(!)	Alert draws attention to critical information that has changed this year.
📞	**Contact** Contact information on who to contact for assistance.
VHP	**Book Table of Contents** Click the purple VHP circle logo, located at the bottom left corner, to return to the main TOC.

Chapter 17 Includes: (Continued)

Alert
Alert draws attention to critical information that has changed this year.

Contact
Contact information on who to contact for assistance.

Book Table of Contents
Click the purple VHP circle logo, located at the bottom left corner, to return to the main TOC.

Utilization Management Department

VHP's Utilization Management (UM) program includes services encompassing utilization management, complex case management, and disease management.

Utilization Management's hours of operation are Monday - Friday 8:00 AM – 5:00 PM (excluding holidays).

Utilization Management
Phone: **1.408.885.4647**
Fax: **1.408.885.4875**
www.valleyhealthplan.org

> **Note:** VHP uses the term "utilization management" and "medical management" interchangeably, though medical management is generally inclusive of utilization management functions.

Utilization Management Program Overview

VHP's utilization management (UM) program is designed to facilitate members' ability to access the right care, at the right place, and at the right time. The UM program is comprehensive and applies to all eligible members across all lines of business, age categories, and range of diagnoses. The UM program incorporates most care settings including preventive care, emergency care, primary care, specialty care, acute care, post-acute care, short-term care, and ancillary care.

The UM program is designed to:

1. promote the provision of medically appropriate care;

2. monitor, evaluate, and manage resource allocation; and

3. monitor cost effectiveness and quality of care delivered to VHP's members through multidisciplinary, comprehensive approach and process.

UM functions include:

- Prior authorization

- Concurrent review and discharge planning

- Transitions of care

- Retrospective reviews

- Continuity of care

The UM program helps ensure that members receive health care services that are a covered benefit, medically necessary, appropriate to the member's condition, rendered in the appropriate setting and that meets professionally recognized standards of care. VHP's UM staff utilizes evidence-based nationally recognized standard criteria. In addition, UM staff use VHP's policies and informational resources

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to determine the medical necessity of health care services to be provided. At least annually, the UM program description, policies, and procedures are reviewed by the Utilization Management Committee (UMC). Under the guidance of the UMC, the UM program is revised as necessary to meet the rapidly evolving landscape of today's health care environment.

UM Program Activities

- Monitor and assess the delivery of care, including review and evaluation of medical necessity and appropriateness, under- and over-utilization of services, continuity and coordination of care, timeliness, cost effectiveness, and quality of care and service.

- Ensure that members have access to the appropriate care and services as described in the members' Evidence of Coverage (EOC), as applicable and consistent with accepted standards of medical practice.

- Retain the ultimate responsibility for the determination of medical necessity for VHP members and ensure that authorization requests are handled efficiently and in accordance with VHP and regulatory timeliness standards.

- Monitor services to evaluate utilization patterns and assess suspected fraud, waste, and abuse.

- Monitor performance to ensure qualified health care professionals perform all components of utilization review.

- Maintain a process for a licensed physician to conduct reviews on all cases that do not meet medical necessity criteria or service requests that are not addressed by established criteria.

- Ensure consistency of UM review and decision-making processes via inter-rater reliability tests.

- Ensure the confidentiality of member information.

The UM staff work collaboratively with contracted providers in the community to assure the delivery of appropriate, cost effective, quality, evidence-based health care services.

Affirmative Statement Regarding Financial Incentives

VHP affirms that:

1. A UM decision is based solely on the appropriateness of care and services and existence of coverage.

2. VHP does not reward providers or other individuals for issuing denials of coverage.

3. Financial incentives for UM decision makers do not encourage decisions that result in under utilization.

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UM Program Structure and Committee

The UM Department is responsible for all VHP members. VHP's Chief Medical Officer (CMO) oversees all clinical services. The structure of UM is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services. Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect multiple entities both internally and externally to VHP.

Utilization Management Committee

The UMC promotes the optimal utilization of health care services while protecting and acknowledging member rights and responsibilities, including the right to appeal denials of service. The UMC also monitors the utilization of health care services by VHP members in all programs to identify areas of under- or over-utilization that may adversely impact member care. UMC meetings are held quarterly and are chaired by VHP's CMO. The UMC is comprised of contracted community physicians and advance practice providers. UMC roles and responsibilities include:

- Provide oversight for appropriateness and clinical criteria used to monitor care and services provided to VHP members.

- Monitor data and reports and identify opportunities for improvement of internal processes and systems.

- Evaluate effectiveness of actions taken.

- Review, evaluate, and analyze data to identify under or over-utilization patterns.

- Review care management issues related to continuity and coordination of care for members.

Prior Authorization

Prior authorization is a request to VHP's UM Department for approval of services before the service is delivered. Prior authorization ensures that a requested service is a covered benefit, meets medical necessity criteria, and is rendered by an appropriate provider. Requested services will also be reviewed to ensure that the most appropriate setting is being utilized and assess whether the member may benefit from case management.

Prior authorization is subject to a member's eligibility and covered benefits at the time of service. Authorizations for certain elective and scheduled services must be obtained from VHP prior to rendering the requested service to ensure reimbursement. Reimbursement is still subject to a member's eligibility on the date service.

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NOTE: Verify a member's eligibility before providing any service. Failure to obtain authorization may result in an administrative claim denial. VHP's network providers are contractually prohibited from holding any member financially liable for any service administratively denied by VHP for failure of the provider to obtain timely authorization. failure of the provider to obtain timely authorization.

Authorization is not required for the following services:

- Sensitive services related to sexual assault, substance/alcohol abuse, pregnancy, family planning, sexually transmitted diseases, HIV testing and abortion.

  – Members may elect to seek sensitive services from a provider of their choice.

  – If these services are performed by a provider not designated as the member's PCP, and **primary care services** are requested by the member, the provider performing the sensitive services should direct the member to seek such primary care services from the member's PCP to ensure on-going continuity of care and follow-up. Primary care services performed by a provider not designated as the member's PCP may result in an administrative claim denial.

  – The provider performing the sensitive services should transmit records to the PCP as appropriate and in compliance with HIPAA and state and other federal regulations.

- Emergency room and post stabilization services. Providers must notify VHP of emergency inpatient admissions within 24 hours of admission or as otherwise set forth in the provider's agreement with VHP for ongoing concurrent review and discharge planning. Clinical information may be required for ongoing authorization of services.

Please note these important key points:

- Authorization must be obtained prior to the delivery of certain elective and scheduled services.

- Inpatient admissions require notification within 24 hours of admission.

- Newborn admissions require notification within 24 hours of admission for an additional authorization.

- Observation stays require notification within 24 hours of the service.

Prior authorization is not required for the following services if rendered by a VHP contracted provider:

1. Urgent care

2. Routine laboratory tests, ultrasounds, and x-rays, assuming that such services are performed in conjunction with a service not requiring prior authorization or an authorized specialty care visit

3. Fetal non-stress testing

4. Immunizations and vaccinations, which are rendered at VHP contracted pharmacies

5. HIV testing or family planning

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6. Telehealth services for behavioral health and urgent care visits

7. Emergency medical transportation

8. Behavioral health counseling services

9. Sensitive services as defined above

Summary of Services Requiring Prior Authorization

(!) **Note:** Except for urgent or emergent services, out-of-network services require prior authorization.

(!) **Prior Authorization Requirements for VHP Members**
The table below reflects services that require prior authorization and is not intended to be a comprehensive list of covered services. As this information is subject to change, please see: **www.valleyhealthplan.org/sites/m/mm/FormsResources/Pages/auths.aspx** or contact UM at **1.408.885.4647**.

Category of Service	Services Requiring Prior Authorization
Behavioral Health	• Applied Behavior Analysis (ABA) Services • Electroconvulsive Therapy (ECT) • Intensive Outpatient Program (IOP) • Psychiatry • Psychological Testing
Durable Medical Equipment (DME)	• Bone stimulators • Breast pump • Baclofen Pump, Insulin Pump, Continuous Glucose Monitoring Device (CGM) and Supplies • Customized DME (e.g., Diabetic Shoes, Compression Sleeves) • DME Repair Services • Formula and Enteral Therapy • Hearing Aids and Hearing Aid Repairs • Hospital Bed and Mattress • Medical Equipment and Supplies (e.g., IV Pole, Syringes, Catheters, Wound Care Supplies)

No prior authorization is required if VHP provides secondary coverage for a covered service; however, the Explanation of Payment (EOP) from the primary insurer must be attached to the claim for processing based on coordination of benefit (COB) rules.

Category of Service	Services Requiring Prior Authorization
Durable Medical Equipment (DME)	• Mobility Devices and Accessories (e.g., Power Wheelchairs, Scooters, Manual Wheelchairs, Motorized Wheelchairs, Cushion, Foot and Head Rests) • Negative Pressure Wound Therapy System or Wound Vac • Other Specialty Devices (e.g., Speech Generating Device) • Prosthetics and Orthotics • Respiratory Equipment and Supplies (e.g., Oxygen, Bilevel Positive Airway Pressure (BiPAP), Continuous Positive Airway Pressure (CPAP), Ventilators, Airway Clearance Vest) • Vision Aids as treatment for Aniridia and Aphakia
Experimental/Investigational Treatment, Procedures and Drugs	• Clinical Trials[2] • Investigational and Experimental Drug Therapies • Investigational and Experimental Procedures • New Technologies non-FDA approved for use (e.g., Robotic surgery) • Non-FDA approved and/or off-label use
Home Health/Hospice	• All Home Health Services (Registered Nurse, Physical, Speech and Occupational Therapists, Home Health Aide, etc.) • Home Intravenous (IV) Infusions • Hospice Services

No prior authorization is required if VHP provides secondary coverage for a covered service; however, the Explanation of Payment (EOP) from the primary insurer must be attached to the claim for processing based on coordination of benefit (COB) rules.

Category of Service	Services Requiring Prior Authorization

Inpatient Admissions	• All Admissions for:
	  – Acute Inpatient Psychiatric
	  – Partial Hospital Psychiatric
	  – Residential Mental Health
	  – Substance Use Disorder, including Detoxification
	• All Elective Inpatient Admissions to:
	  – Acute Care Hospitals
	  – Long Term Acute Care (LTAC)
	• Rehabilitation and Therapy Services:
	  – Acute Inpatient Rehabilitation or Acute Rehabilitation Unit (AIR/ARU)
	  – Skilled Nursing Facilities (SNFs)
	  – Subacute Nursing Facilities

Medications	• Infusion Services • Injections (excluding Immunizations) • Non-Formulary Prescription Drugs
Non-Contracted Providers, Tertiary Providers, and/or Quaternary Providers	• All Non-Urgent/Non-Emergent Services rendered by Non-Contracted Providers, Tertiary Providers, and/or Quaternary Providers such as Lucile Packard Children's Hospital, Stanford Children's Health, Stanford Health Care, and Stanford Hospital & Clinics

No prior authorization is required if VHP provides secondary coverage for a covered service; however, the Explanation of Payment (EOP) from the primary insurer must be attached to the claim for processing based on coordination of benefit (COB) rules.

Category of Service	Services Requiring Prior Authorization
Outpatient Services and Procedures	- Acupuncture and Chiropractic Services - All Outpatient Procedures (e.g., Amniocentesis, Nerve Conduction Studies, Varicose Vein Treatment, Performed Outside of a Physician's Office, Endoscopy and Colonoscopy) - All Outpatient Surgery (e.g., Cataract Surgery, Tonsillectomy, Abdominoplasty, Panniculectomy, Breast Reduction and Augmentation Surgery) - Automated External Defibrillator (AED), Holter, Mobile Cardiac Telemetry Monitoring Services - CAR T-cell Therapy - Cardiac and Pulmonary Rehabilitation - Chemotherapy and Radiation Treatment (e.g., Brachytherapy, Neutron Beam Therapy, Proton Beam Therapy, Intensity-Modulated Radiation Therapy (IMRT), Stereotactic Body Radiation Therapy (SBRT), Stereotactic Radiosurgery (SRS), Gamma-ray and CyberKnife) - Dental Surgery, Dental Anesthesiology, Jaw Surgery and Orthognathic Procedures - Diagnostic Imaging: – Bone Density (DEXA Scan) – Computerized Tomography Scans (CT) – Magnetic Resonance Angiography (MRA) – Magnetic Resonance Imaging (MRI) – Nuclear Cardiology Procedures (Stress Tests/Treadmill) – Positron-Emission Tomography (PET/PET-CT) – Single-Photon Emission Computerized Tomography (SPECT)

No prior authorization is required if VHP provides secondary coverage for a covered service; however, the Explanation of Payment (EOP) from the primary insurer must be attached to the claim for processing based on coordination of benefit (COB) rules.

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Category of Service	Services Requiring Prior Authorization
Outpatient Services and Procedures	• Dialysis: All Hemodialysis and Peritoneal, Continuous Ambulatory Peritoneal Dialysis (CAPD), Automated Peritoneal Dialysis (APD), Continuous Cycling Peritoneal • Dialysis (CCPD) • Gender Reassignment Therapy and Surgery • Genetic Testing and Counseling • Hyperbaric Oxygen Therapy • Infertility Services • Non-routine Laboratory, Ultrasound and Radiology Services3 • Outpatient Therapies (Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST)) • Pain Management Services • Palliative Care Services • Reconstructive Procedures • Second Opinions • Sleep Studies • Spinal Procedures, including all Injections • Surgical Implants (e.g., Pacemaker, Baclofen Pump, Neuro and Spinal Cord Stimulators, Cochlear Auditory Implant) • Temporomandibular Disorder (TMJ) Treatment • Unclassified Procedures • Ventricular Assist Device
Transplants	• All Transplants and Related Services
Non-Emergency Medical Transportation: Non-Interfacility	• Non-Emergency Medical Transport (NEMT), including Fixed-Wing Air Transport4

No prior authorization is required if VHP provides secondary coverage for a covered service; however, the Explanation of Payment (EOP) from the primary insurer must be attached to the claim for processing based on coordination of benefit (COB) rules.

Category of Service	Services Requiring Prior Authorization
Other	• All Non-Urgent/Non-Emergent Services Performed Out-of-Area • All Non-Covered Services • All Services not Covered by the Member's Primary Insurance and VHP Provides Secondary Coverage • Any service that Exceeds the Benefit Limit

No prior authorization is required if VHP provides secondary coverage for a covered service; however, the Explanation of Payment (EOP) from the primary insurer must be attached to the claim for processing based on coordination of benefit (COB) rules.

Concurrent Review and Discharge Planning

VHP performs ongoing concurrent review for inpatient admissions through electronic medical record, on-site or telephonic methods, through contact with the hospital's utilization and discharge planning departments and with the member's attending physician when necessary. When determining ongoing medical necessity and appropriate level of care, UM reviews the member's status, treatment plan, and any results of diagnostic testing or procedures. Urgent concurrent review decisions are made within 24 hours of receipt of the request.

Retrospective Review

Retrospective review is an initial review of services already rendered to a member, but for which authorization was not obtained. Retrospective review for inpatient services is conducted when a member has been discharged following an inpatient admission prior to notifying VHP. Notification to VHP may have untimely due to extenuating circumstances. Retrospective review may also be conducted for outpatient services when authorization was not obtained due to extenuating circumstances. Requests for retrospective review must be submitted promptly. A decision is made within 30 calendar days following receipt of the request for retrospective review.

If a provider is unable to obtain authorization before providing a service or medical item, VHP will respond to a retrospective/post-service authorization request received within 30 calendar days of initiation of the service or provision of the medical item. **A retrospective authorization request will be denied for untimely submission if VHP receives it after 30 calendar days.** Post-service authorization requests must be accompanied by documentation explaining why the authorization was not requested prior to the provision of services. VHP's response will inform the provider of the decision to approve, modify or deny the retrospective authorization request.

If an authorization request is submitted for a member who has obtained eligibility retroactively, the

retrospective authorization request must be received by VHP within 30 calendar days of the eligibility date. Retrospective authorizations received after 30 calendar days will be denied for untimely submission.

How to Submit a Prior, Retrospective, and Inpatient Authorization

Authorization for prior, retrospective, inpatient (concurrent) services can be submitted online or by fax, see below. For information regarding prior authorizations for pharmaceuticals see <u>Chapter 16, "Pharmacy Services."</u>

Obtaining access to Valley Express

Step 1: Complete a Valley Express (VE) Access form, available online at: **https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/ve-ext-access-req-frm.pdf**

Step 2: Submit the completed form via email to: **VEAccess@vhp.sccgov.org**

Step 3: Upon receipt, your Provider Relations Representative will review and submit for processing to VHP's Information Technology Department.

> (!) Note: Processing of VE access requests can take up to seven business days.

Accessing Valley Express

Step 1: Using the credentials supplied to the provider by VHP, log into VE securely at: **https://www.vhpvalleyexpress.com/vhp/**

Welcome to the online system realtime Referral Management System: Valley Express!

WELCOME TO VALLEY EXPRESS

Valley Express is a VHP system only.

Old referrals on VMC patients will still be available as read only as a link from the OTHER LINKS menu screen - LEGACY VALLEY EXPRESS.

For Help with Valley Express, please contact the HELPDESK at 408-885-5300 and open a ticket for the Valley Express Help Desk.

User Name: _____

Step 2: On the left-hand side, select "Input Authorizations" and the type of authorization

requested (i.e., "Admissions," "Procedures/Referrals," or "Retro").
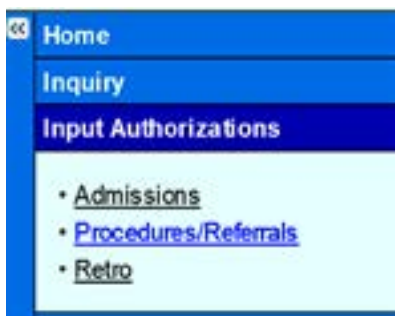
Step 3: Fill out the information below and follow the prompts accordingly.

Submitting Authorizations by Fax

Providers can submit authorizations by completing the VE Authorization Request Form and faxing the form to VHP's UM department at **1.408.885.4875**. The form and directions can be found at: **https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/documents/P_TARForm_EN_091421_placement_MedMgt.pdf.**

Key points about Submitting Authorization Requests

When submitting authorizations, it is important to clearly identify the service requested and the medical justification. Failure to include the medical justification may result in a delay in processing the authorization request.

The following information is required when submitting a VHP Authorization Request Form:
- Diagnosis(ses) (ICD-10);

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- Service(s) requested (CPT-4);

- Number of visits requested;

- Facility name if the request is for an inpatient admission or outpatient facility services;

- Provider location if the request is for an ambulatory or office procedure;

- Admission date or proposed surgery date if the request is for a surgical procedure;

- Name of provider requested to render the services;

- Name of the provider submitting the request; and

- Name of the member and the member's VHP ID number.

Providers are encouraged to make referrals to Santa Clara Medical Center (SCVMC), O'Connor Hospital and St. Louise Regional Hospital through SCVMC's provider portal, EpicCare Link. To gain access to the SCVMC portal, a provider must enroll as follows:
1. Send an email to **VMCProviderRelations@hhs.sccgov.org** with your name and practice address.

2. SCVMC's Provider Relations Department will send you forms to complete, which include a Participant Access Agreement and a User Access Agreement.

More information can be found on the SCVMC provider site.

Signing up for EpicCare Link access has many benefits to both providers and VHP members:
1. Receive notifications about VHP's members use of health care services, such as outpatient/ Emergency Department visits, admissions, discharges, and new laboratory results. VHP's contracted providers can configure the Epic system to alert you, or your office staff via email or text message.

2. Request referrals electronically and send/receive messages from specialists regarding your VHP members.

3. Electronically place orders for laboratory and imaging tests.

4. Help you comply with Protecting Access to Medicare Act (PAMA) through the use of the American College of Radiology CareSelect Clinical Decision Support Tool when ordering advanced imaging.

5. Access the VHP member's medical record to view laboratory and imaging results and read inpatient and ambulatory notes.

6. View medical records from other EPIC institutions or provider organizations through Care Everywhere.

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Clinical Information Needed for Decision-Making

VHP requires providers to submit clinical documentation for all prior authorization requests. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), VHP is entitled to request and receive protected health information (PHI) for purposes of treatment, payment, and healthcare operations, without the authorization of the member.

The clinical information necessary for authorization requests may include but is not limited to:
- Reason the service is medically necessary, including documentation (such as History and Physical and progress notes);
- Reason for the authorization request (e.g., primary and all other diagnoses , diagnosis code(s), planned surgical procedure(s), procedure code(s), and when applicable, surgery date);
- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed);
- Discharge plans; and
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate.

If additional clinical information is required, VHP will notify the provider of the additional information needed to complete the authorization process.

Completing the request correctly will reduce the need for additional information and prevent delays. If the VE Authorization Request Form does not contain sufficient information for review, a Delay Letter will be sent to the provider requesting additional clinical documentation. If the additional information is not received by VHP within 14 calendar days, the request will be reviewed and may be denied due to lack of sufficient clinical information.

Authorization Considerations
- Submit a VHP Authorization Request Form as far in advance of the planned service date as possible to allow for review. VHP requires prior authorization requests be submitted at least 14 calendar days prior to the start of service for non-urgent conditions.
- The provider is responsible for verifying whether the VHP member has other insurance, including Medicare. **If the services requested are not covered by the primary payer, authorization must be obtained from VHP or the claim may be denied.**

- For services that require authorization, failing to obtain authorization in advance may result in a denied claim.

- All services are subject to member eligibility and benefit coverage.

- Clinical and coverage criteria may differ between lines of business.

- Repair or replacement of rental equipment is the responsibility of the durable medical equipment (DME) company that provided the equipment.

- VHP reserves the right to choose who to rent or buy DME from and whether to authorize DME as a rental or purchase.

Medical Necessity

"Medical Necessity" refers to services that are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. These services must be rendered by a licensed health care provider to diagnose or treat an illness, injury, or medical condition which the VHP Medical Director determines to be:

- Appropriate and necessary for the diagnosis, treatment, or care of a medical condition;

- Not provided for cosmetic purposes;

- Not primarily custodial care (including domiciliary and institutional care);

- Not provided for the convenience of the member, the member's attending or consulting physician or another provider;

- Performed in the most efficient setting or manner to treat the member's condition;

- Necessary as determined by an order of the court; and

- Within standards of medical practice as recognized and accepted by the medical community.

Clinical Decisions

Utilization management decision-making is based on the appropriateness of care and services, as well as the existence of coverage. In addition, it involves the referral of members to other programs providing coverage of specific conditions. Individual authorization requests are reviewed by the UM department according to predetermined criteria, protocols, and the medical information from the physician or other provider. Authorization decisions are based upon evidence based VHP policies and nationally recognized standards including:

1. MCG Health (formerly Milliman Care Guidelines)

2. VHP's UMC approved guidelines

3. Apollo Medical Managed Care Clinical and Evidence Based Guidelines

4. National Specialty Boards and nationally published guidelines

5. Reports from peer reviewed medical literature, where there is a higher level of evidence and study quality

6. Nationally recognized standards of practice and professional standards of safety and effectiveness recognized in the U.S. for diagnosis, care, or treatment

7. Expert opinions, including:

   a. Clinical advisors serving on VHP committees

   b. Independent Medical Review (IMR)

VHP's IMR process provides an impartial review of medical decisions made by VHP related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and related issues. Standards, criteria, and guidelines are the foundation of an effective UM Program as they furnish VHP's licensed UM staff an objective "decision" support tool to determine the following:

- If services are medically necessary;

- If services are rendered at the appropriate level of care; and

- If the quality of care meets professionally recognized industry standards.

The criteria used for reviews are available upon request. Approval of an authorization request does not guarantee payment. Reimbursement is subject to the member's eligibility status and benefit at the time of service.

> **Note:** Authorization requests that are denied for medical necessity must be reviewed by VHP's Medical Director.

VHP's Medical Director may deny an authorization request when the medical review criterion/criteria is/are not met. Requested services may be denied for the following reasons:

1. Member ineligibility;

2. Not a covered benefit;

3. No treatment request or prescription;

4. Exhausted benefit or exceeded allowable benefit;

5. Services requested are available within the member's chosen or primary network;

6. Inappropriate setting or level of care;

7. Services determined not to be medically necessary; and/or

8. The services are carved out of VHP's financial responsibility (e.g., California Children Services).

Authorization Determination Timeframes

Upon receipt of a request for services pursuant to an Authorization Request Form, VHP decisions are made as expeditiously as the member's health condition requires. Decisions are rendered within the following timeframes based upon the type of request:

- **Standard/Routine Authorization Decisions:**

    o For standard service authorizations, a decision and notification are made within five business days from VHP's receipt of information reasonably necessary for a determination.
    - This timeframe does not exceed 14 calendar days from receipt of the request (unless an extension is requested). Failure to submit necessary clinical information within the designated time frame may result in an administrative denial of the requested service.

- **Urgent/Expedited Pre-Service Requests**

    o For urgent/expedited pre-service requests, a decision is made within 72 hours of receipt of the request.

- **Urgent Concurrent Review**

    o For urgent concurrent reviews and ongoing inpatient admissions, decisions are made within 24 hours of receipt of the request. VHP may extend the timeframe for making urgent concurrent decisions in certain situations.

- **Retrospective Decisions:**

    o In cases where the review is retrospective, VHP's decision to approve, modify, or deny the request will be communicated to the member and the requesting provider within 30 calendar days of VHP's receipt of information reasonably necessary to make a determination. Retrospective requests do not qualify for expedited review.

VHP makes every effort to return authorization determinations quickly. Urgently needed care should never be delayed while awaiting prior authorization. The "urgent" designation is intended for cases in which the requested service must be provided as quickly as possible to avoid harm to the member. At times, requests may be received as urgent because elective services were scheduled, but authorizations were not requested in advance. VHP will do its best to respond to such requests but may ask that such procedures be rescheduled if there is insufficient time to obtain the clinical information and complete the required review. Definition of an "urgent" prior authorization request is one in which the requested service is medically needed within 72 hours of submission.

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Notification of Decisions

Providers submitting an Authorization Request Form will receive notification of VHP's UM decision via fax or the VE email system within 24 hours of VHP's decision. When an authorization request is determined not to meet medical necessity criteria, the member, provider, and facility (as applicable) are notified of the following:

- The decision

- The opportunity for the provider to request a peer-to-peer conversation with a VHP Medical Director

- The ability for the member to file an appeal

    o Providers may file an appeal at the request of the member. Refer to <u>Chapter 15, "Provider Disputes and Member Grievances and Appeals."</u>

Responding to Adverse Determinations

Providers may obtain the criteria used to make a denial decision by contacting UM at **1.408.885.4647 (option 4)**. Providers may also discuss a denial decision with a physician or other appropriate reviewer at the time of notification. Providers may contact the Medical Director by calling VHP's UM Department at **1.408.973.6460**.

Continuity of Care

Members have the right to continuity of care (COC) for covered services. If the member has an acute condition, a serious chronic condition, a pregnancy, a terminal illness, or a newborn child between birth and age 36 months under medical care, the member may be eligible to continue to receive treatment from their provider (e.g., physician or hospital). This may occur either at the time of a provider's termination as a VHP provider, or from a non-participating provider at the time of enrollment in VHP. Members may request a copy of VHP's COC policy as well as assistance with requesting COC by contacting Member Services at **1.888.421.8444** (for TTY, contact California Relay by dialing **711** or **1.800.735.2929**.) The Request for Continuity of Care member intake form is included in the **Appendix**.

If a member has been receiving services from a PCP who is not contracted with VHP and the member wishes to continue receiving services from the PCP, the member may be approved for continuation of care based upon the medical condition and eligibility of the member. However, the duration of approval for continuation of care will not exceed 12 months. At a minimum, the following criteria must be satisfied for a Continuity of Care Request submitted by the member to be considered:

- The member established a relationship with a provider that was not contracted with VHP prior to the effective date of the member's enrollment in VHP;

- The provider meets applicable professional standards and does not have a record of any disqualifying quality of care issues; and

- The provider is willing to continue treating the member and accepts VHP's reimbursement rates.

Second Opinions

Members have a right to seek, and cannot be denied, a second opinion. Second opinions within the member's chosen and preferred network are a covered service. Second opinions outside of the member's chosen and preferred network are a covered service **only with** prior authorization by VHP's Medical Director or designee. VHP will authorize a second opinion upon request of either the member or a qualified health care professional. Below are the criteria for approval of a second opinion **outside** of the member's chosen network.

- The member questions the reasonableness or necessity of a recommended surgical procedure.
- The member questions a diagnosis or treatment plan for a condition that threatens loss of life, limb, bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.
- The clinical indications are not clear or are complex and confusing.
- A diagnosis is in doubt due to conflicting test results.
- The treating provider is unable to diagnose the condition.
- The member's clinical condition is not responding to the prescribed treatment within a reasonable period of time given the condition, and the member is requesting a second opinion regarding the diagnosis or continuance of the treatment; or
- The member has attempted to follow the treatment plan or has consulted the initial care provider and still has serious concerns about the diagnosis or treatment plan.

Assistant Surgeon

VHP may reimburse an assistant surgeon for services rendered based on the medical necessity of the procedure itself and the assistant surgeon's presence at the time of the procedure. Hospital medical staff by-laws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity. Reimbursement is not guaranteed when the patient or family requests that an assistant surgeon be present for the surgery unless medical necessity is indicated.

Emergency Services

Emergency services are covered inpatient and outpatient services that are necessary to enable stabilization or evaluation of an emergency medical condition and are provided by a health care professional qualified to furnish emergency services.

VHP defines an **emergency medical condition** as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that

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a prudent layperson with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;

- Serious impairment to bodily functions;

- Serious dysfunction of a bodily organ or part; or

- In the case of a behavioral condition, placing the health of such person or others in jeopardy.

Members may access emergency services at any time without prior authorization or prior contact with VHP. Emergency services are covered by VHP when furnished by a qualified provider (including non-network providers) until the member is stabilized. VHP does not deny payment for treatment obtained under either of the following circumstances:

- A member had an **emergency medical condition**, including those cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of the above emergency medical condition.

- A representative from VHP or a network provider instructs the member to seek emergency services.

If a member is admitted to a contracted hospital from the emergency room, VHP requires notification within 24 hours of the admission. The provider may not bill, charge or collect payment from a member for any emergency care services that are not otherwise allowable under the member's EOC.

Requirements for Inpatient Admission

Elective admission

- Prior authorization is required for elective admissions. All requests are reviewed for medical necessity in advance. An approved length of stay will be authorized based on MCG Health guidelines. The facility must provide documentation if the requested length of stay is extended due to complications and/or unforeseen factors. An administrative denial letter will be issued for all elective admissions and transfers to non-participating facilities not authorized by VHP.

Emergency admission

- All emergency services will be covered by VHP. Contracted hospitals are required to notify VHP of an admission within 24 hours of the member's presentation for treatment at the hospital (or as otherwise specified in the provider's agreement with VHP) by calling **1.855.254.8264** or **1.408.885.4647** or by faxing VHP at **1.408.885.4875**. The fax must include the face sheet with the admitting diagnosis(ses). Failure to comply with this notification or the notification provision included in the provider's agreement with VHP may result in a denial for untimely notification.

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Acute Inpatient Rehabilitation and Long-Term Acute Care Admission

Prior authorization is required for inpatient rehabilitation and long-term acute care (LTAC). All requests are reviewed for medical necessity in advance and concurrently throughout the admission until discharge.

Inpatient Admission to Sub-acute and Skilled Nursing Facilities

VHP waives the three-day hospital stay requirement for skilled nursing facility (SNF) coverage. Prior authorization is required for all SNF admissions and authorizations are processed according to state and federal regulations. All SNF admissions are subject to concurrent review and must meet medical necessity admission criteria and continued stay criteria. The following requirements must be met for a SNF admission:

- Medically stable with medical or surgical comorbidities manageable and not requiring acute medical attention.

- Requires care that is directly related and reasonable for the presenting condition and/or illness.

- Expected improvement from medical and/or rehabilitative intervention within a reasonable and predictable period of time.

- Member who requires rehabilitative services must exhibit a decline in physical function for the rehabilitation services to be considered medically appropriate.

The following information and/or documentation is required as part of the continued stay/concurrent review for a SNF admission:

- Documentation of progress toward long and short-term goals;

- Expected length of treatment, discharge plan and discharge needs;

- Nursing assessments and progress notes, rehabilitation therapy assessment and a weekly therapy update form; and

- Provider orders and progress notes.

Disclosure of Utilization Management Criteria

Providers may request a written copy of VHP's UM policies and procedures and/or VHP's UM medical necessity criteria utilized in the decision-making process. For a copy of the UM criteria or guidelines, contact VHP's Provider Relations Department at **1.408.885.2221**.

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CH 18:
Case Management

This Chapter Includes:

1. **Case Management Program**

2. **Health Risk Assessment Screening**

3. **Case Management Team**

4. **How to Contact VHP's Case Management Team**

5. **Entities Delegated for Case Management**

Alert
Alert draws attention to critical information that has changed this year.

Contact
Contact information on who to contact for assistance.

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Case Management Program

VHP's case management (CM) program is designed to help providers manage their VHP members and to assist members in obtaining needed services from community resources. These resources include covered and non-covered services when determined to be medically appropriate for the needs of the member. VHP's CM team manages care for members whose needs are functional and social as well as those with complex medical and/or behavioral conditions. For pregnant members, pre-natal care, peri-natal mood disorders and maternal mental health are areas where CM can assist members in receiving the appropriate, supportive care and services. Children with special health care needs may be at higher risk and are also appropriate for VHP's CM program. VHP uses a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and health education. Case managers partner with providers to help the member achieve their self-management health care goals.

All VHP members are eligible for comprehensive CM programs, including complex CM, condition-specific CM, and autism spectrum disorder (ASD) CM. Members who have been identified with chronic complex, acute complex, high-risk conditions, or gaps in care, regardless of condition, generally benefit from intensive one-on-one advocacy care, care coordination, and education provided through CM programs.

Health Risk Assessment Screening

VHP offers health risk assessment (HRA) screening to all Commercial Employer Group, CoCA and IFP members. HRA screening is voluntary, free of charge, and confidential. Information gathered includes current and past medical conditions, psychosocial network and support systems, barriers to health care, gaps in care, and self-care ability. The results are used in two ways: cumulative and individual. At the cumulative level, the information is used by VHP for program development. At the individual level, the information is used to identify members for case management programs and other quality initiatives

Case Management Team

The CM team includes a Medical Director, Registered Nurses, Licensed Clinical Social Workers, Medical Social Workers, Care Coordinators and Community Outreach Specialists. The member's designated case manager conducts a comprehensive assessment of the member's medical, behavioral, and psychosocial needs through the administration of a health risk assessment (HRA) which supports the identification of barriers to care or well-being. The case manager is also responsible for the development and implementation of an individualized care plan as well as coordination of care among the member's caregivers and providers to achieve good quality of care outcomes.

Below Is a more detailed description of case management at VHP:
Complex Case Management:
- Case management for the highest risk or highest cost members; or
- Members with multiple, ongoing physical, behavioral and social concerns.

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Condition Case Management:
- Focuses on improving the health of members with chronic conditions through enrollment in specific programs such as biometric monitoring for members with class II and IV heart failure;
- Supports the treatment plan established by the provider through education and health coaching; and
- Provides care coordination to address the member's needs.

ASD Case Management:
- Provides access to resources for members with ASD diagnoses who are under 21 years of age;
- Provides support and addresses barriers for families caring for special needs children; and
- Partners with the primary care providers and coordinates care across multiple specialty areas.

How to Contact VHP's Case Management Team

A CM team member is available to help providers manage their VHP members. You may initiate a real-time referral via email at **vhpcasemgmt@vhp.sccgov.org**, through fax at **1.408.947.4251** or Epic/HealthLink if you are part of the County of Santa Clara Health System by using the VHP Case Management Referrals email portal (**see below**).

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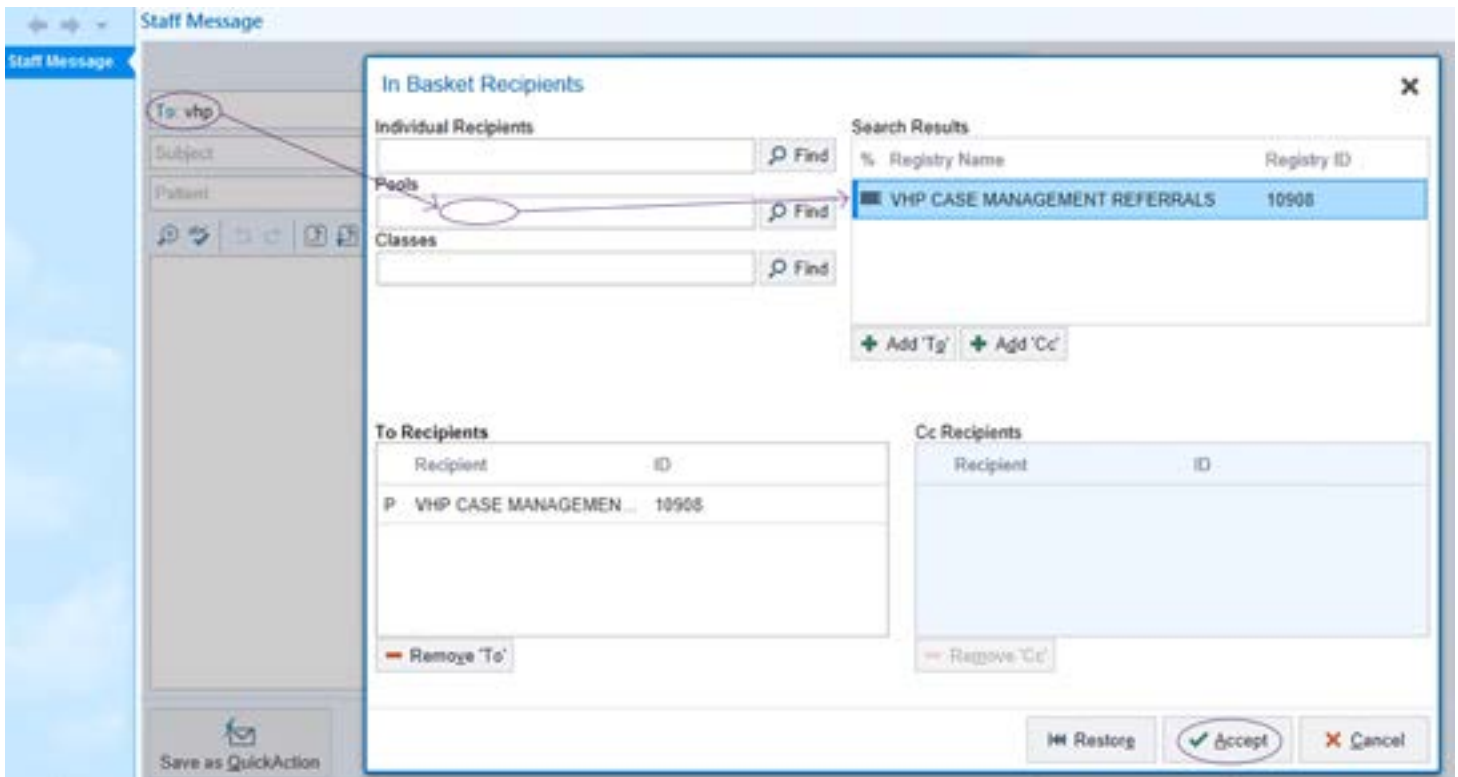
Entities Delegated for Case Management

If an independent practice association (IPA), medical group, or other organized provider entity has been delegated responsibility for Case Management, refer to **Chapter 22, "Delegated Entities."** Conformance with VHP's policies, procedures, protocols, protocols, VHP's Provider Manual and all applicable regulatory and accrediting standards is required.

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Behavioral Health Services

This Chapter Includes:

	Alert Alert draws attention to critical information that has changed this year.
	Contact Contact information on who to contact for assistance.
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Behavioral health services are covered benefits. Covered benefits include outpatient mental health counseling, outpatient treatment services, and inpatient treatment services for members who are diagnosed with severe mental illness (SMI), serious emotional disturbances (SED), substance use disorders (SUD), or autism spectrum disorder (ASD).

Provider Expectations: Integrating Physical and Behavioral Care

VHP encourages and supports collaborative efforts among PCPs, as well as other medical/surgical health care providers. VHP supports whole-person health care because physical conditions and mental illness and substance use are interdependent and the treatment of both must be coordinated.

Physical health conditions can and often do exacerbate behavioral health conditions or can trigger behavioral health issues, for example, the onset of depression following a cardiac event. Behavioral health conditions can and often do impact physical health conditions. For example, a person with depression may lack the motivation or energy to follow the physical therapist's recommendations for rehabilitation after a surgery.

The treatment and medication regimens for physical and behavioral health conditions may interact. For example, many psychotropic medications can cause weight gain, which can exacerbate metabolic syndromes or diabetes.

Even a differential diagnosis can be complicated if the assessment fails to consider potential physical causes for apparent mental conditions, such as psychosis-like symptoms triggered by high liver enzymes in members with liver disease.

Communication with the Primary Care Providers

VHP encourages ongoing consultation between PCPs and their members' behavioral health providers. In many cases, the PCP has extensive knowledge about the member's medical condition, mental status, psychosocial functioning, and family situation.

Communication of this information at the point of referral or during treatment is encouraged with member consent, when required. Behavioral health providers may find the member's PCP on the front-side of the member ID Card or providers may contact Case Management at **1.408.885.2600** (see Chapter 3, "Enrollment and Eligibility" and the section entitled "Sample ID Card" for the location of the PCP's name and telephone number). Behavioral health providers should refer members with known or suspected untreated physical health problems or disorders to the member's PCP for examination and treatment.

Behavioral health providers should also communicate with the member's PCP when there is a behavioral health problem or treatment plan that can affect the member's medical condition, or the treatment being rendered by the PCP. In addition, the behavioral health provider should communicate with other

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behavioral health clinicians who may also be providing services to the member. Examples of issues that should be communicated to the PCP include:

- Prescription medications, particularly when the medication has potential side effects, such as weight gain, that could complicate medical conditions, such as diabetes.

- The member is known to have abused over the counter, prescription or illegal substances in a manner that can adversely affect medical or behavioral health treatment.

- The member has laboratory work indicating the need for PCP review and consult.

- The member is receiving treatment for a behavioral health diagnosis that can be misdiagnosed as a physical disorder (i.e., panic symptoms can be confused with cardiac symptoms).

- The member's progress towards meeting the established goals of the treatment plan has stopped progressing, potentially impacting or exacerbating the member's physical health or well-being.

VHP recommends that the provider use all available communication means to coordinate treatment for members. All communication attempts and coordination activities must be clearly documented in the member's medical record.

Outpatient Behavioral Health Services and Authorization Requirements

Behavioral health treatment services can be provided by a physician or non-physician, providers such as Psychologists (PhD), Licensed Marriage and Family Therapist and Counselors (LMFT/MFCC) and Licensed Clinical Social Workers (LCSW), or other health professionals permitted by California law.

Behavioral health covered services include, but are not limited to:

- Assessment, diagnosis, individual and group therapy, and psychological testing when necessary to evaluate a behavioral health disorder

- Evaluation and treatment prescribed after psychological and neuropsychological testing

- Outpatient covered services for the purpose of monitoring drug therapy

- Chemical dependency covered services include but are not limited to:

- Evaluation and treatment for alcohol or drug dependency and medical treatment for withdrawal symptoms

- Day treatment programs

- Intensive outpatient programs

- Individual and group chemical dependency counseling

- Transitional residential recovery services, defined as chemical dependency treatment in a nonmedical transitional residential setting

Outpatient behavioral health services do not require a prior authorization. **Outpatient chemical dependency services and services to be rendered by a psychiatrist do require prior authorization.**

Inpatient Behavioral Health Services and Authorization Requirements

VHP's Utilization Management (UM) program strives to make certain that:

- A member's care meets medical necessity criteria.

- Treatment is specific to the member's condition, is effective, and is provided in the least restrictive, most clinically appropriate site and level of care.

- Services provided comply with VHP's quality improvement requirements.

- UM policies and procedures are systematically and consistently applied.

- The focus for members and their families' centers on promoting resiliency and hope.

VHP's utilization review decisions are made in accordance with currently accepted behavioral health practices, and in consideration of the special circumstances of each case that may require deviation from the norm stated in the screening criteria. VHP's medical necessity criteria are used for the approval of medical necessity. Plans of care that do not meet medical necessity guidelines are referred to a licensed physician advisor, psychiatrist or psychologist for review and peer-to-peer discussion.

VHP conducts UM in a timely manner to minimize any disruption in the provision of behavioral health services. The timeliness of decisions adheres to specific and standardized timeframes yet remains sufficiently flexible to accommodate urgent situations.

VHP's UM Behavioral Health program is under the direction of a licensed Medical Director or physician designee. The UM staff regularly confers with the Medical Director or physician designee on cases where there are questions or concerns. VHP ensures that only clinically licensed behavioral health providers review and make denial determinations.

Inpatient behavioral health treatment services are available and are covered when authorized by VHP. Prior authorization is required for all inpatient behavioral health services.

VHP covers inpatient psychiatric hospitalization at a contracted hospital. Coverage includes:

- Inpatient behavioral health residential treatment

- Crisis residential treatment

- Short-term treatment in a crisis residential program within a licensed psychiatric treatment facility with 24-hours-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis

- Psychiatric observation for an acute psychiatric crisis

- Inpatient substance use services, such as dependency recovery services, education and counseling, and short-term acute detoxification

> ⚠ Note: Inpatient behavioral health services that are court ordered, or as a condition of parole or probation, are excluded from the member's benefit plan, unless determined medically necessary by a VHP Medical Director.

MDLIVE Telehealth Benefit

VHP members may access primary care and behavioral health providers for a wide range of urgent and non-emergency services via secure online video, phone or MDLive web application 24 hours a day, seven days a week. MDLive providers can diagnose symptoms, prescribe non-narcotic medication (if needed), and send e-prescriptions to the member's VHP pharmacy of choice.

Members may register for access to the MDLive benefit by visiting **www.mdlive.com/VHP** or by calling **1.888.467.4614**. Language assistance is available. For additional information, visit VHP's website at **https://www.valleyhealthplan.org/sites/m/pages/mdlive.aspx**.

Members are also eligible to receive telehealth services from VHP behavioral health and medical services providers. Providers must use a GT modifier when billing for telehealth. For behavioral health, the services may include but are not limited to initial evaluation, individual therapy, and medication management. For more information regarding telehealth and billing, see VHP's website at **https://www. valleyhealthplan.org/sites/g/files/exjcpb771/files/41320-VHP-Telehealth-Provider-Communication-Web.pdf**.

Applied Behavior Analysis

In addition to outpatient and inpatient treatment services, VHP covers behavioral health treatment (BHT) services such as Applied Behavior Analysis (ABA) and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practical, the functioning of VHP members diagnosed with Autism Spectrum Disorder (ASD).

ABA is the application of behavioral principles to everyday situations, intended to increase or decrease targeted behaviors. ABA has been used to improve areas such as language, self-help, and play skills, as well as decrease behaviors such as aggression, self-stimulatory behaviors, and self-injury. For those with ASD, treatment may vary in terms of intensity, frequency, duration, and complexity. When describing the treatment and the treatment goals for ABA services, the terms focused or comprehensive are used.

See below for the definition of these terms:

Focused ABA is direct care provided for a limited number of behavioral targets. It is appropriate for those who need treatment only for a limited number of key functional skills or have such acute problem behavior that its treatment should be the priority.

Comprehensive ABA is for treatment of multiple affected developmental domains, such as cognitive, communicative, social, emotional, and adaptive functioning.

Qualified autism service providers must be either:

1. Certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified; or

2. Licensed as a physician and surgeon, physical therapist, occupational therapist, PhD, LMFT, educational PhD, LCSW, professional clinical counselor, speech-language pathologist, or audiologist acting in accordance with the provider's applicable business and professions code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

Rules of participation require that providers only assign VHP members to qualified autism professionals or qualified autism paraprofessionals under a treatment plan prescribed by and supervised by a qualified autism service provider.

Qualified autism professionals and qualified autism paraprofessionals must meet the following minimum qualifications:

A qualified autism service professional must meet the following criteria:

- Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.

- Provides treatment according to a treatment plan developed and approved by the qualified autism service provider.

- Meets the education and experience qualifications as described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.

- Has training and experience in providing services for a pervasive developmental disorder or autism.

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- Is employed by a qualified autism service provider or by a provider group that employs qualified autism service providers responsible for the autism treatment plan.

A qualified autism service paraprofessional is an unlicensed and uncertified individual who meets all the following criteria:

- Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.

- Provides treatment and implements services for a treatment plan developed and approved by a qualified autism service provider.

- Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.

- Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or provider group that employs qualified autism service providers.

- Is employed by a qualified autism service provider or an entity or provider group that employs qualified autism service providers responsible for the autism treatment plan.

In summary, ABA services may be rendered directly by a licensed behavioral health provider with additional documented training in applied behavior analysis, a Board Certified Behavior Analyst (BCBA), or a paraprofessional under the direct supervision of a qualified autism service professional.

Eligibility Requirements

To be eligible for ABA services, members must meet all the following coverage criteria:

1. Be under 21 years of age

2. Have a recommendation from a licensed physician, surgeon, or a licensed PhD that evidence-based behavioral health treatment (BHT) services are medically necessary

3. Be medically stable

4. Be without a need for 24 hour medical/nursing monitoring or procedures provided in a hospital

ABA services are provided under a BHT plan that has measurable goals over a specific timeline for the specific member being treated and has been developed by a licensed ABA provider.

- The BHT plan must be reviewed, revised, and/or modified no less than once every six months by a licensed provider and submitted to VHP or its designee for review if continued treatment is indicated.

- The BHT plan may be modified if medically necessary as determined by VHP.

- ABA services may be discontinued by VHP when the treatment goals are achieved, discharge criteria are met, or services are no longer medically necessary.

All ABA services must meet medical necessity criteria to ensure coverage.
The following services do not meet medical necessity criteria or qualify as VHP covered ABA services for reimbursement:

1. Services rendered when continued clinical benefit is not expected.

2. Provision or coordination of respite, day care, or educational services, or reimbursement by a parent, legal guardian, or legally responsible person for costs associated with participation under the BHT plan.

3. Treatment whose sole purpose is vocationally or recreationally based.

4. Services, supplies or procedures performed in a non-conventional setting, including, but not limited to, resorts, spas, and camps.

5. Services rendered by a parent, legal guardian, or legally responsible person.

6. Services that are not evidence-based behavioral intervention practices.

7. Custodial care. For purposes of BHT services, custodial care:

   a. Is provided primarily for maintaining the member's or anyone else's safety.

   b. Could be provided by persons without professional skills or training.

Initial and Continuation of ABA Services Requirements

All the following are required for the initiation and continuation of ABA services:

1. A comprehensive evaluation of the member by the member's PCP or specialist identifying the need for treatment of ASD.

2. A prescription from the member's PCP or specialist that includes specific treatment goals.

3. Initial BHT plan completed by a licensed ABA provider (see below "Behavioral Treatment Plan Requirements").

4. An assessment of the goals and progress every six months.

5. An annual review by the prescribing PCP or specialist, in consultation with the ABA provider, that includes:

   a. Documentation of benefit to the member;

   b. Identification of new or continuing treatment goals; and

   c. Development of a new or continuing treatment plan.

Note: Additional hours of ABA services will be authorized by VHP if determined to be medically necessary and appropriate when applying VHP continued service criteria and best practices. In addition, authorization of covered services by VHP is an indication of medical necessity, not a confirmation of a member's eligibility nor a guarantee of payment.

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Behavioral Treatment Plan Requirements

The approved BHT plan must meet the following criteria:

1. Be developed by a qualified, licensed ABA service provider for the specific member being treated.

2. Include a description of the member's information, reason for referral, brief background information (e.g., demographics, living situation, home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.

3. Be person-centered and based upon individualized, measurable goals and objectives over a specific timeline.

4. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.

5. Identify measurable long, intermediate, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.

6. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.

7. Include the member's current level of skills and behaviors, parent's current level of skills/ behaviors, the criteria for mastery, date of introduction, and estimated date of mastery as well as specify the plan for generalization and report goal as "met", "not met", or "modified" (include explanation of goal achievement).

8. Utilize evidence based BHT services with demonstrated clinical efficacy tailored to the member.

9. Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual BHT service provider responsible for delivering the services.

10. Include care coordination involving the parents or caregiver(s), school, state disability programs and others as applicable.

11. Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.

12. Deliver ABA services in a home or community-based setting, including clinics. Any portion of medically necessary ABA services that are provided in school must be clinically indicated as well as proportioned to the total ABA services received at home and community.

13. Include an exit plan/criterion.

ABA Services Provided by Registered Behavior Technician (Paraprofessionals) Requirement

If a Registered Behavior Technician (RBT) is involved in delivering ABA therapy services, the RBT must:

1. Be supervised by a BCBA, or Board-Certified Behavior Analyst- Doctoral (BCBA-D). Supervision by a licensed ABA service provider may be direct or indirect.

2. Deliver services according to the ABA therapy treatment plan, whether in an individual or group setting.

3. Directly train family members to support generalization and maintenance of achieved behaviors.

4. Ensure family involvement through modeling and coaching.

5. Review the member's progress with the BCBA or BCBA-D at least every two weeks to confirm that the ABA therapy treatment plan still meets the member's needs. If changes are clinically indicated, they must be made by the lead behavior analysis therapist.

6. Consult with the BCBA or BCBA-D when considering modifications to technique, when barriers and challenges occur that inhibit implementation of the treatment plan, and as otherwise clinically indicated.

7. Keep documentation of each visit with the member and family to include targeted behavior, interventions, response, modifications in techniques, and a plan for the next visit, along with behavior tracking sheets that record and graph data (if applicable) collected for each visit.

8. Document the time spent on each service.

9. Maintain signed and dated documentation of family's confirmation that a visit occurred.

Supervision Guidelines

Supervision must be delivered to each paraprofessional, RBT, or Board Certified Assistant Behavioral Analyst (BCaBA) level staff and should adhere to the following:

1. Supervision should be provided at a minimum of one hour per month, not to exceed eight hours per month, at a ratio of one hour per every ten hours of direct service. This is in line with the Behavior Analysis Certification Board (BACB) guidelines of two hours of supervision for every ten hours of direct service. Given these requirements, consider indirect supervision by the BCBA as treatment planning.

2. Per BACB guidelines, RBTs must receive ongoing supervision by a BCBA for a minimum of five percent of the hours spent providing applied behavior analytic services per month, including at least two face-to-face, synchronous supervisory contacts.

3. Supervision can be in a group or individual format. When providing supervision, only supervision can be billed, not the paraprofessional's or BCaBA's time. Supervision ratios are consistent with two- and three-tier treatment models. The cumulative recommendation hours for supervision shall

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not exceed the BACB (2014) standard level of care, which is two hours of supervision for every ten hours of direct treatment.

4. Enhanced Supervision is available due to situational crises, transitions, the need for extensive analysis of a refractory problem behavior, or other factors. Providers need to provide clinical rationale for enhanced supervision.

5. The ratio of indirect to direct services should not exceed twenty percent.

Documentation Requirements

In addition to the documentation required above, the ABA therapy services provider shall maintain the following records for each member:

1. The prescription for ABA services;

2. Documented Comprehensive Diagnostic Evaluations (CDEs);

3. ABA assessments, functional behavior assessments or analysis, and time-limited individualized treatment plans;

4. Current school Individualized Education Program (IEP) with identified treatment goals, if applicable;

5. All collected member data and graphs;

6. Supervision notes;

7. Notes supporting parenting training, including but not limited to, sign-in sheets and description of content, if service was provided in a group setting;

8. Notes supporting the member's participation in group activities and interventions consistent with the treatment plan;

9. Documentation of coordination of services with other healthcare providers rendering services to the member or the member's family (e.g., school therapist as part of IEP); and

10. Daily documentation of the member's participation in the program, which must include all the following:

    a. Member's name;

    b. Date of service;

    c. Service type (e.g., direct therapy or parent training);

    d. The location where the services were provided;

    e. Amount of treatm`ent time;

    f. Name(s) of the provider(s) who worked directly with the member;

    g. The goals targeted for the day and strategies used to pursue those goals;

    h. The intervention format (e.g., individual or group therapy);

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i. Graphed or numeric data that tracks the member's progress and participation for the day; and

j. The signature, title, and credentials of the person completing the daily documentation.

BHT Code Submission

HCPCS codes and applicable modifiers must be reported in accordance with contractually specified requirements. Please review the VHP provider agreement for appropriate use of billing codes.

> **Note:** Providers who use electronic medical records may summarize hard copy data to create daily documentation as shown in the example below. Hard copy data must be maintained in a shadow chart and be available to VHP upon request. Providers who maintain paper records may set up their daily data sheets to reflect the required information, which will suffice as the day's note.

See the Example Below:

Name: *Susie Smith*
Date: *12/12/20*
Time statement: *180 minutes*

Clinicians: *Sally Jones BCBA, Sara Smith RBT and Joe Rough LABA*

Goals targeted/intervention format/treatment strategies and progress:
- *Expressive labels targeted during 1-1 DTT instruction (progress: 80% correct response across 3 sets of 10 trials)*
- *Social initiations targeted during dyadic PRT instruction (progress: 60% correct across 10 prompted trials; 3 spontaneous initiations)*
- *Imitating symbolic play actions targeted during dyadic PRT instruction (progress: 70% correct across 10 prompted trials; no spontaneous)*

Signed: *Sara Smith RBT*

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Quality Management

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Quality Management Program Overview

VHP is committed to continuous and measurable improvement in the delivery of quality health care for its members. VHP's culture, systems and processes are structured around its mission to continuously monitor performance to improve the health of all enrolled members.

The VHP Quality Management (QM) department oversees clinical quality assurance (QA), quality monitoring, and performance improvement (PI). One of the requirements of the National Committee for Quality Assurance is that VHP utilize provider performance data for quality and performance improvement. VHP agreements with providers require their cooperation with VHP's QM and PI activities.

VHP conducts ongoing systematic review of health care services provided to members. Services are coordinated and monitored using applicable accrediting standards, regulatory requirements, and statutes, promulgated by the following organizations, including not but limited to:

- National Committee for Quality Assurance (NCQA)
- Accreditation Association of Ambulatory Health Care (AAAHC)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare and Medicaid Services (CMS)
- Department of Managed Health Care (DMHC)
- California Health and Safety Code (HSC)
- California Department of Insurance (CDI)
- Office of the Patient Advocate (OPA)
- Covered California (CoCA)

Quality Management, in collaboration with other teams throughout VHP, is responsible for the following activities:

- Define, oversee, continuously evaluate, and improve the quality, efficacy and efficiency of health care delivered through its provider network.
- Ensure that medically necessary covered services are available and accessible to members, taking into consideration the member's cultural and linguistic needs.
- Ensure VHP's contracted network of providers cooperates with VHP's PI and quality improvement (QI) initiatives.
- Ensure that timely, safe, medically necessary, and appropriate care is available.
- Ensure that VHP consistently meets quality standards as required by contract, regulatory agencies, accreditation bodies, recognized care guidelines, and the health care industry.
- Promote health education and disease prevention designed to promote life-long wellness by

encouraging and empowering each member to adopt and maintain optimal health behaviors.

• Maintain a quality network of providers based on NCQA credentialing standards.

Quality Management Structure and Committee

VHP's QM Department is comprised of registered nurses and analysts. The three pillars of QM are quality monitoring, PI, and QA. Data analytics, information technology, and security are essential components in QM's work.

The Quality Management Committee (QMC) has the responsibility of overseeing quality programs and overall quality of care. Committee membership includes staff from QM, Case Management, Utilization Management, Pharmacy, Provider Relations, and Member Services, as well as community providers (behavioral health, pediatrics, gerontology, obstetrics, and internal medicine). The QMC is physician-led and all voting members are physicians.

The QM staff also serve on other committees, including the Utilization Management Committee, Pharmacy & Therapeutics Committee, Credentialing Committee, Compliance Committee, and Appeals and Grievances Committee.

Annual Quality Management Work Plan

The QM annual work plan mirrors the VHP strategic plan and key performance metrics, as well as special initiatives. Providers are encouraged to offer input to the QM work plan. Provider participation in quality projects, including surveys and evaluations, assists QM in achieving work plan goals and is an essential component of the QM Department's success at VHP.

The QM Department's annual work plan includes monitoring clinical PI indicators and clinical areas to identify opportunities for improving population health, care coordination, member safety, and member experience. QM, with QMC's approval, maintains clinical goals by which performance is measured, assessed, and evaluated. The QM annual work plan reflects progress of QI objectives and activities throughout the year.

These yearly, planned QI objectives and activities fall under the following categories:

• Quality of clinical care

• Safety of clinical care

• Quality of healthcare service

• Member experience

• Others as needed

Quality Monitoring

The QM program incorporates continuous PI (CPI) in the work plan, which addresses VHP's diverse membership, and includes objectives to:

- Promote healthcare equity in clinical areas.

- Improve network adequacy to meet the needs of underserved groups.

- Foster VHP and provider compliance with cultural, linguistic, and disability access requirements.

- Improve cultural, linguistic, and disability responsiveness in communications and materials.

- Improve other areas of needs that VHP deems appropriate.

The following sources of information are monitored and may be considered for inclusion in the QM work plan:

- Quality of care and adherence to guidelines, measured through Healthcare Effectiveness Data and Information Set (HEDIS) performance

- Establishment of and compliance with preventive health guidelines

- Establishment of and compliance with clinical practice guidelines

- Acute and chronic care management

- Provider network adequacy and capacity (access to care and availability of providers)

- Selection and retention of providers (credentialing and recredentialing)

- Behavioral health benefits

- Delegated entity oversight

- Continuity and coordination of care

- Utilization management, including under- and over-utilization of services

- Provider and employee cultural competency

- Cultural, linguistic, and disability access requirements, including the accuracy of provider language capability

- Member experience

- Provider experience

- Member appeal and grievance system

- Provider dispute and complaint system

- Patient safety

- VHP organization performance and service

QM annually reviews data, reports, and other performance measures as identified through the annual work plan to assess the effectiveness of initiatives. The evaluation includes a review of completed and continuing activities, audits, trending of performance data, and analysis of quality improvement projects.

The annual evaluation also addresses barriers, successes, and challenges in the determination of QI effectiveness. The annual evaluation report includes information on monitoring of clinical quality assurance activities, identification of quality of care and service issues, an assessment of the overall effectiveness of QI initiatives, progress toward influencing network-wide safe clinical practices, and qualitative analysis of annual goals with improvement plans for those that were not met.

Potential Quality Issues

A potential quality issue (PQI) is a suspected deviation from expected clinical performance, clinical care, or outcome of care, which requires additional review to determine if there is an actual quality concern or issue. The PQI process may be initiated by a member, a VHP member's authorized representative, provider representative/practitioner or internal staff. PQIs require prompt attention from practitioners and medical staff. To report a PQI, submit a completed Potential Quality Issue Reporting Form to QM via secure email at **vhpqmimprovement@vhp.sccgov.org** or fax to **1.408.943.8125**. A copy of the form is included in the **Appendix**.

VHP has a comprehensive review system to address PQIs. PQIs are forwarded to QM for clinical review that may include an evaluation and peer review by providers with similar clinical degrees and experience. A QI Registered Nurse (QI Coordinator) is responsible for collecting clinical health records and provider responses to support the comprehensive evaluation of a PQI.

PQIs are reviewed by a VHP Medical Director for final determination. When necessary, the case may also be reviewed by the QM Department's Peer Review Committee. Based on the findings and case outcome, requests may be made to the provider for additional documentation or follow-up actions, depending upon the severity of the issue(s). PQIs require prompt attention from providers and clinical staff.

All completed PQIs are forwarded to VHP's Credentialing Department for inclusion in the provider's credentialing file. PQIs and related documentation, including corrective action plans (CAP) are reviewed during the credentialing and recredentialing processes.

The frequency and severity of PQIs are monitored. Depending on the number and severity of PQIs for a given provider or service location, an onsite audit may be conducted by VHP. Based on the severity and frequency of a provider's PQIs, a provider may be terminated from VHP's network.

> **Note:** PQI reviews are protected from discovery by the Health and Safety Code Section 1370 and Evidence Code 1157.

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Hospital Quality

VHP's current hospital quality activities include monitoring the cesarean section (C/S) and hospital-acquired condition (HAC)/ hospital-associated infection (HAI) rates.

To comply with CoCA requirements, hospitals must report quarterly to the Maternal Data Center of the California Maternal Quality Care Collaborative the number of nulliparous women with term, singleton baby in a vertex position delivered by C/S.
VHP annually monitors the C/S rate through Cal Hospital Compare and the Smart Care California Hospital C-Section Honor Roll List.

Finally, to comply with CoCA and CMS requirements, hospitals must report quarterly to the CDC National Healthcare Safety Network HAC/HAI rates using CDC's reporting criteria on:

- Cather-associated urinary tract infection

- Central line-associated bloodstream infection

- Colorectal surgical site infection

- Clostridium difficile infection

- Methicillin-resistant Staphylococcus aureus infection

VHP annually monitors HAC/HAI rates through Cal Hospital Compare.

Healthcare Effectiveness Data and Information Set

Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that health care consumers have reliable information for performance comparison among health plans. Health plans are required to submit annual HEDIS reports to regulatory agencies such as NCQA and CMS. A subset of HEDIS measures are collected and reported for the commercial business lines each year. VHP monitors and tracks HEDIS scores to evaluate clinical quality performance and other important dimensions of care and services provided by VHP's network of providers. VHP providers are required to actively contribute to HEDIS scoring by continuously closing gaps in care for members as well as making accessible member medical records during annual HEDIS audits.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Every year, members assess the quality of care they receive and their experience and satisfaction with VHP plans and services through NCQA and CMS. Also, every year, as part of ongoing efforts to gather additional feedback from members, VHP hires an outside vendor to administer member experience and satisfaction surveys. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the

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Qualified Health Plan Enrollee Survey (QHP for CoCA) uses standardized sets of questions to evaluate many health plans across the U.S. The surveys consist of 43 questions for the commercial employer group line-of-business (LOB) and 68 questions for the CoCA LOB. Member feedback is evaluated on the following:

Determination of member ratings of:
- Rating of Health Plan
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist

Assessment of member perceptions related to:
- Customer Service
- Claims Processing
- Plan Information on Costs
- Getting Care Quickly
- Getting Needed Care
- How Well Doctors Communicate
- Shared Decision Making
- Health Promotion and Education
- Coordination of Care

Provider involvement with VHP members directly impacts VHP's CAHPS and HEDIS scores. Therefore, taking the following actions can contribute to ensuring accurate reflection of VHP's performance:

1. Inform members that they may receive a survey asking about their satisfaction (CAHPS).
2. Encourage members to complete and mail back the CAHPS survey.
3. Strive for timely and helpful customer service to members.
4. Make sure members receive appointments within the acceptable timely access requirements. See <u>Chapter 12, "Timely Access Requirements</u>" for access and appointment availability requirements.
5. Screen members for high blood pressure and high cholesterol.
6. Recommend and/or administer the flu shot during flu season.
7. Recommend and promote health education and wellness programs.
8. Make an extra effort to help every member get the care and support they need.

The continued support of VHP providers is greatly appreciated and significantly contributes to VHP's performance on the CAHPS and QHP surveys. Contact VHP's Provider Relations Department at **1.408.885.2221** to learn more about the CAHPS and QHP surveys.

Preventive Health and Clinical Practice Guidelines

VHP supports the development and use of evidence-based clinical guidelines or resources to assist providers and members in selecting the best preventive, diagnostic, or screening options. Preventive health and clinical practice guidelines are reviewed and updated annually using the most current published medical evidence from the CDC and U.S. Preventive Services Task Force recommendations. The guidelines are updated annually by VHP's Utilization Management Committee.

Maternal Mental Health Program

VHP's Maternal Mental Health Program was created to improve and promote excellent quality of care and outcomes for women during their perinatal experience. In partnership with local providers, organizations, and agencies, VHP participates in a Maternal Mental Health Collaborative with the goal of strengthening the network that supports women receiving comprehensive services and care, including, education, preventive screening, and treatment resources throughout pregnancy and postpartum.

Provider Responsibilities for Quality Management Program

VHP's network providers are contractually obligated to participate in quality assurance and safety, quality monitoring, population health, and PI activities. Some activities are required by regulatory bodies and others are optional. The list includes:

- Participate on the QMC.

- Provide expert consulting for peer review activities.

- Act as an expert adviser for clinical quality activities.

- Partner with VHP in quality clinical studies/projects.

- Participate in routine health record and onsite audits. These procedures are outlined in QM policies COM 6004 - Health Record Standards and Requirements and COM 6007 - Evaluation of Provider/Practitioner Clinical Care and Service. Copies of these policies are available upon request from VHP's Provider Relations Department at **1.408.885.2221**.

- Provide VHP with notice of PQIs, adverse or sentinel events

- Participate in surveys and audits as mandated by the regulators or accrediting bodies (e.g., Provider Access and Availability, After Hours Survey and Provider Satisfaction Survey).

- Provide/make accessible health records for the annual HEDIS audit to VHP's contracted medical reviewer (without cost to VHP per the provider's agreement).

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- Assist in continuously improving VHP's HEDIS scores, including timely submission of accurate claims and encounter data, participating in annual medical record reviews, and submission of electronic medical records data, which are obligations set forth in provider's agreement with VHP.

- VHP providers, including hospitals, are required to participate in quality management activities and provide member information and health records, to the extent allowed by applicable state and federal laws, for quality of care and service reviews.

- VHP's contracted providers are required to participate in PQI reviews and provide requested documents in accordance with the time frames specified by VHP.

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CH 21:
Regulatory & Compliance Requirements

This Chapter Includes:

	Alert
(!)	Alert draws attention to critical information that has changed this year.
📞	**Contact** Contact information on who to contact for assistance.
VHP	**Book Table of Contents** Click the purple VHP circle logo, located at the bottom left corner, to return to the main TOC.

Compliance Program Overview

The goal of VHP's compliance program is to ensure that all VHP members receive appropriate and quality health care services through the provider network in compliance with all applicable state and federal rules and regulations as well as VHP contractual requirements. Program scope includes but is not limited to:

- Provide oversight and ongoing monitoring of delegated responsibilities of VHP's provider network.

- Require the implementation of Corrective Action Plans (CAPs) by providers to address deficiencies concerning the provision of health care services or VHP performance standards.

- Establish policies and procedures to identify, investigate, and resolve potential or actual fraud, waste, and abuse (FWA) activities.

- Establish education/training opportunities and provide other available resources to assist providers to be compliant with the Health Insurance Portability and Accountability Act (HIPAA) requirements and member rights concerning privacy and confidentiality.

- Establish education/training opportunities and provide other available resources to assist providers in achieving and maintaining compliance with state and federal requirements.

- Establish education/training opportunities to assist providers with compliance concerns and issues regarding fraud, waste, and abuse.

Audit and Oversight Activities

VHP does not delegate its compliance program responsibilities to providers. However, providers are required to comply with all state and federal compliance program requirements. VHP staff works with the provider's staff to administer compliance activities and implement CAPs to rectify deficiencies. Providers and their staff are encouraged to work with VHP to ensure compliance with all VHP performance standards.

To ensure that all VHP members receive appropriate health care services, VHP's staff perform an annual audit of contractual responsibilities and services delegated by VHP to a provider or provider entity. VHP's audit program for delegated providers includes, but is not limited to the following activities:

- Annual on-site visits and/or desktop audits of providers to ensure compliance with applicable state and federal requirements.

- Annual evaluations are comprehensive assessments of the delegate's performance, including both compliance with applicable standards and the extent to which the delegate's activities promote VHP's overall goals and objectives for the delegated function.

- Identification and evaluation of deficiencies, and determinations regarding corrective actions, including procedures for ensuring those actions are implemented.

- Ad-hoc on-site visits to review provider activities to ensure compliance with program requirements.

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- Ongoing monitoring through review of periodic reports and data required as outlined in the provider's delegation agreement.
- Review of all provider books and records and information as may be necessary to demonstrate provider compliance with state, federal, and VHP contractual requirements.
- Records include, but are not limited to, financial records and books of accounts, all medical records, medical charts and prescription files, and any other documentation pertaining to health care services rendered to VHP members, and other information as reasonably requested by VHP.

Additional information regarding delegated providers is in <u>Chapter 22, "Delegated Entities."</u>

Provider General Responsibilities

All providers agree to comply with state and federal regulations and VHP's policies, instructions and "Applicable Requirements" as defined in the provider's agreement with VHP. Providers also agree to fully cooperate with audits and inspections by state, federal, VHP, and/or their designees and to cooperate, assist, and provide information as requested, and maintain records (including records of education, training, and supporting documentation) for a minimum of ten years.

Providers shall ensure that all their related entities, contractors, or subcontractors, and downstream entities (known as "Business Associates" under HIPAA) involved in transactions related to VHP's lines of business maintain and provide access to all pertinent contracts, books, documents, papers, and records (including records of education, training, and supporting documentation) necessary for compliance with state and federal requirements.

> ⓘ Providers are responsible to conduct annual general and specialized compliance training for their employees.

About Health Insurance Portability and Accountability Act Privacy

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that requires VHP and its providers to protect the security and privacy of its members' protected health information (PHI). HIPAA provides VHP members with certain privacy rights, including the right to file a privacy compliant.

PHI is defined as any individually identifiable health information, including demographic information. PHI includes a member's name, address, phone number, medical information, social security number, date of birth, email address, driver's license number, financial information, etc.

VHP supports its providers' efforts to comply with HIPAA requirements. Because patient information is critical to carrying out health care operations and payment functions, VHP and its providers must work together to comply with HIPAA requirements in terms of protecting patient privacy rights, safeguarding PHI

and providing patients with access to their own PHI upon request.

Medical Record Confidentiality

The provider's medical records system must allow for prompt retrieval of each record when the member presents for services. Providers must maintain members' medical records in a detailed and comprehensive manner that accomplishes the following:

- Conforms to good professional medical practice

- Facilitates an accurate system for follow-up treatment

- Permits effective professional medical review and medical audit processes

Medical records must be legible, signed and dated. Providers must furnish a copy of a member's medical record upon reasonable request by the member at no charge, and the provider must facilitate the transfer of the member's medical record to another provider at the member's request. Confidentiality of and access to medical records must be provided in accordance with the standards mandated in HIPAA and all other state and federal requirements.

Providers must permit VHP and regulatory agencies to review VHP's members' medical records for the purposes of:

- Monitoring the provider's compliance with medical record standards

- Capturing information for clinical studies or HEDIS

- Quality monitoring

- For any other reason specified by VHP

Security

Medical records must be secure and inaccessible to unauthorized access to prevent loss, tampering, disclosure of information, alteration, or destruction of the records. Information must be accessible only to authorized personnel within the provider's office, VHP, regulatory agencies, or to persons authorized through a legal instrument. This is true whether your medical records are electronic or on paper. Office personnel must protect information about individual patient conditions or other related information so that it is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas. Providers must have security systems in place to provide back-up storage and file recovery, to provide a mechanism to copy documents, and to keep recorded input from being altered.

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Storage and Maintenance

Providers must secure active medical records, so they are inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed and organized, and that permits effective patient care and quality review while maintaining confidentiality. Inactive records are to remain accessible for a period of time that meets state and federal guidelines. Electronic record keeping (using an electronic health record (EHR)) system procedures shall be in place to preserve patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems.

Misrouted PHI

Providers are required to review all member information received from VHP so that no misrouted PHI is included. Misrouted PHI includes information about members that are not treated by a specific provider. PHI can be misrouted to providers by mail, fax, email, or electronic Remittance Advice. If your office receives misrouted PHI from VHP, you must inform VHP immediately upon receipt of the PHI. The PHI must be either destroyed or safeguarded as long as it is retained. Providers are not permitted to misuse or re-disclose misrouted PHI. If you cannot destroy or safeguard misrouted PHI, contact VHP's Compliance & Privacy Office at:

> **Valley Health Plan**
> **Attention: Compliance & Privacy**
> **2480 North First Street, Suite 160**
> **San Jose, CA 95131**
>
> Fax: **408.885.6886**
> Telephone: **1.408.885.3794**
> Email: **complianceofficer@hhs.sccgov.org**

Reporting a Breach of PHI

A breach is an unauthorized disclosure of PHI that violates either federal or state laws (HIPAA Privacy Rule and State Information Practices Act of 1977) or PHI that is reasonably believed to have been acquired by an unauthorized person. A breach may be paper or electronic. Some examples of a breach include, but are not limited to:

- Sending or releasing a member's PHI to an unauthorized person(s); and
- Misplacing or losing any electronic device (e.g., thumb drive, laptop) that contains PHI.

If the provider or their staff detect or suspects an internal breach of PHI or a breach by a related entity, contractor, subcontractor, or downstream entity (collectively referred to as a "Business Associate") involving a VHP member, you must notify VHP immediately upon discovery. To report a breach, call VHP's Compliance & Privacy Office at:

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Valley Health Plan
Attention: **Compliance & Privacy**
2480 North First Street, Suite 160
San Jose, CA 95131

Fax: **1.408.885.6886**
Telephone: **1.408.885.3794**
Email: **complianceofficer@hhs.sccgov.org**

The notice of breach must contain:
1. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;
2. The location of the breached information;
3. The unauthorized person(s) who used the PHI or to whom the disclosure was made;
4. Whether the PHI was actually acquired or viewed;
5. A description of the types of PHI that were involved in the breach;
6. Safeguards in place prior to the breach;
7. Actions taken in response to the breach;
8. Any steps VHP's members should take to protect themselves from potential harm resulting from the breach;
9. A brief description of what the provider or Business Associate is doing to investigate the breach, to mitigate harm to VHP's members, and to protect against further breaches; and
10. Contact procedures for VHP members to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, website or postal address. [45 C.F.R. Sections 164.410(c) and 164.404(c)].

Entities, contractors, and other Business Associates under HIPAA must take any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations. Business Associates must also comply with 45 C.F.R. Section 164.410 with respect to reporting breaches of unsecured PHI. [42 U.S.C. Section 17921; 45 C.F.R. Section 164.504(e)(2)(ii)(C); 45 C.F.R. Section 165.308(b)]

Fraud, Waste and Abuse
VHP has a comprehensive program in place to detect, prevent, and report fraud, waste, and abuse (FWA) as part of the General Compliance Plan Requirements (42 C.F.R. § 423.504(b)(4)(vi)(H)) and 42 C.F.R. § 422.503(b)(4)(vi).

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Under VHP's FWA program, VHP performs front and back end audits to monitor network providers' compliance with billing requirements. VHP investigates and coordinates efforts to recover erroneous payments, misrepresentative billing, fraud, waste and abuse or other acts resulting in overpayments. Examples of investigation activities include:

- **Services Not Rendered:** Billing for services, treatments, diagnostic tests, medical devices, or drugs never rendered.

- **Bundling and Unbundling:** Separating services, procedures or tests and billing each one separately, which results in greater charge amounts.

- **Duplicate Billing:** Billing for the same services, procedures, medical devices, prescriptions, etc. that have already been billed for on a separate claim.

- **Back Filling:** Billing for part of the global fee before the claim is received reflecting the actual global code.

- **Ghost Patients:** Billing for health care services, treatments, diagnostic tests, medical devices, or drugs provided to a VHP member who either does not exist or who never received the service from a VHP network provider.

- **Kickbacks:** Any offer, payment, solicitation of money, property or remuneration to induce/reward the referral of members or services (e.g., referral fees, productivity bonuses, discounted leases/ equipment, research grants, speaker's fees, and free/discounted travel or entertainment).

- **Upcoding Services:** Deliberately billing for services that are more complex than what was rendered or performed.

- **Lack of Medical Necessity:** Performing (and billing for) services that are not medically necessary to obtain an insurance payment.

- **Falsifying Diagnosis Codes:** Submitting false diagnosis codes to support testing or services not otherwise necessary or covered or submitting diagnosis codes to make a condition appear more severe.

- **Inflating Cost:** Excessive charges for services, procedures, or supplies.

- **Red-Lining:** Providers only accepting healthier members and discouraging enrollment by VHP members they deem to be sicker or at higher risk for serious illness or vice versa.

- **Billing for Non-Medical Necessary Services:** Submitting claims for services not medically necessary, or services not medically necessary to the extent rendered (for instance, a panel of tests is ordered when based upon the member's diagnosis only a few of the tests, if any at all, within the panel were medically necessary).

- **False Certification:** Certifying services that were not medically necessary and/or performed in accordance with all applicable rules and regulations.

- **Falsifying Provider Information:** Changing the rendering provider and/or services to get the claim paid (after the claim was denied).

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- **Billing While Ineligible:** Billing for services after the provider's license has been revoked/restricted or after the provider has been debarred from a government benefits program for fraud and abuse.
- **Submitting a False Claim:** Submitting a claim for items or services resulting from a violation of the Anti-Kickback Statute, the Stark Law, Exclusion Authorities Law, or the Civil Monetary Penalties Law.

Due to the evolving nature of fraudulent and abusive billing, VHP may enhance the FWA program at any time. These enhancements may include but are not limited to creating, customizing, or modifying claims edits, and upgrading software, modifying forensic analysis techniques, or adding new subcontractors to help in the detection of aberrant billing patterns.

Investigations and Audits

VHP has the duty and responsibility to conduct periodic provider audits for suspected fraud, waste, and abuse. VHP monitors and analyzes billing practices to ensure services are correctly billed and paid. Audits are conducted to ensure compliance with applicable federal and state billing and licensing rules, applicable provider contracts and policies and procedures. The reviews are also designed to monitor and detect deficiencies in processes used for coverage determinations and claims adjudication.

Prior to conducting an audit, VHP will send the provider's office a letter of intent. As a contracted provider in VHP's network, you must allow inspection, audit and duplication of all records maintained on all VHP members to the extent necessary for VHP to perform the audit or inspection. This access must be allowed within 30 days of VHP's written request. This includes any EHRs and systems including any electronically stored access logs and data entry for electronic systems. VHP requires that all records and documentation be contained in each corresponding member's medical record at the time of the audit. Audit findings will be communicated to you in writing. Provider audits may result in a determination of overpayment, a request for refund, or other action(s) deemed appropriate by VHP, including termination from VHP's provider network.

Providers must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultations, grand jury proceedings, pre-trail conferences, hearings, trials and in any other process, including investigations.

Provider Education

When VHP identifies through an audit or other means a situation with a provider (e.g., coding, billing) that is either inappropriate or deficient, VHP may determine that provider education is appropriate. VHP will notify the provider of the deficiency and will take steps to educate the provider, which may include the provider submitting a CAP addressing the issues identified and how the provider will cure the issues moving forward.

Corrective Action Plans

As a part of our payment integrity responsibility, VHP evaluates the appropriateness of paid claims. VHP may initiate a formal CAP if a provider does not comply with VHP's billing guidelines or performance standards. VHP will monitor the CAP to confirm that it is in place and addresses the identified billing/performance problems.

Fraud, Waste and Abuse Training

> (!) Provider must administer FWA and general compliance training to employees and contractors used by their organizations.

Reporting Potential Fraud, Waste or Abuse

VHP works to detect, correct, and prevent fraud, waste, and abuse in the health care system. If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, contact VHP's Compliance & Privacy Office at:

Valley Health Plan
Attention: **Compliance & Privacy**
2480 North First Street, Suite 160
San Jose, CA 95131

Fax: **408.885.6886**
Telephone: **408.885.3794**
Email: **complianceofficer@hhs.sccgov.org**

If you prefer to remain anonymous, contact:

Compliance Hotline
Telephone: **1.855.888.1550 (toll-free)**
Web: **www.mycompliancereport.com** (access code SCVH)

CH 22:
Delegated Entities

This Chapter Includes:

!	**Alert**	Alert draws attention to critical information that has changed this year.
📞	**Contact**	Contact information on who to contact for assistance.
VHP	**Book Table of Contents**	Click the purple VHP circle logo, located at the bottom left corner, to return to the main TOC.

Supplemental Information for Capitated and/or Delegated Providers

This information is applicable for VHP's Commercial Employer Group, Covered California and Individual & Family plans for members whose provider, independent practice association (IPA), medical group, or other organized provider entity is paid on the basis of capitation and performs administrative responsibilities on behalf of VHP pursuant to a delegation agreement.

Does this Supplement Apply to Me?

This applies if the provider is a:

- Capitated provider; or

- Delegated provider.

To summarize, this supplement applies if:

1. A VHP member has been assigned to or who has chosen a provider (either an individual participating provider or an entity as defined above) that receives a capitation payment from VHP for that member or for the performance of administrative or clinical functions; and

2. The member is covered under a plan insured by or receiving administrative services from VHP.

Capitated Providers

What is a capitated provider?

Capitation is a payment arrangement for health care providers, which is generally paid based on a per member, per month (pmpm) or a percent of premium. If the provider has an agreement with VHP based on one of these reimbursement methodologies, the provider is considered a capitated provider. VHP pays capitated providers a set amount for each member assigned per period of time, which is generally a month. VHP pays capitation regardless of whether the member seeks care. In most instances, the capitated provider is associated with a medical group or an IPA. Sometimes, the capitated provider is an individual provider, ancillary provider or hospital.

Capitated providers may also be subject to VHP's protocols, policies and procedures related to delegated activities, including by way of example only, submission of encounter data (see Chapter 14, "Encounter Data") and other requirements reflected in the provider's agreement with VHP.

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Delegated Providers

What is a Delegated Provider?

Delegation is a process VHP uses to give another entity the authority to perform specific administrative or clinical functions on behalf of VHP. The functions delegated must be performed in accordance with VHP's policies, procedures, protocols, VHP's Provider Manual and all applicable regulatory and accrediting standards (Applicable Requirements).

Assuming a provider has successfully completed and passed the VHP's pre-delegation audit, VHP may elect to delegate:

1. Utilization management (see <u>Chapter 17, "Utilization Management"</u>);
2. Credentialing (see <u>Chapter 9, "Credentialing and Recredentialing"</u>);
3. Claims adjudication and payment (see <u>Chapter 13, "Claims & Billing Submission"</u>);
4. Case management (see <u>Chapter 18, "Case Management"</u>); or
5. Other clinical and administrative functions.

Refer to the Delegation of Administrative Responsibilities in the provider agreement with VHP to determine which delegated activities, if any, are performed on behalf of VHP.

When VHP delegates any of these responsibilities, the provider is considered a Delegated Provider ("delegated entity" or "delegate"). VHP remains responsible to external regulatory and accrediting agencies and other entities for the performance of the delegated activities. To become a delegate, the provider must demonstrate compliance with VHP's established standards and best practices. Additionally, to remain a delegate, the provider must continuously comply with VHP's standards and best practices. If the delegate is non-compliant with VHP's standards and best practices, VHP may revoke any or all delegated activities.

If an individual provider is associated with a delegated medical group, IPA, or other provider entity, the individual provider must conform to the policies and protocols of the Delegated Provider.

All delegates are formally reevaluated annually. Failure of the Delegated Provider to perform any delegated activity in accordance with VHP's Applicable Requirements may result in a corrective action plan (CAP) or revocation of any or all of the delegated activities and a reduction in the capitation rate paid to the Delegated Provider by VHP.

> (!) VHP retains the right to determine in its sole discretion whether to delegate any functions regardless of results of an audit.

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CH 22: Delegated Entities

Appendix

Printable forms are found in the Appendix. Links to fillable online versions can be found below.

Forms:

1. **Authorized Representative Form**

   https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/P-AuthorizedRepresentativeForm-EN-2020-PR.pdf

2. **Continuity of Care Form**

   https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/Continuity-of-Care-Request-Form.pdf

3. **HIV-Aids Attestation Form**

   https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/HIV-AIDS-Attestation-Form.pdf

4. **Language Attestation Form**

   https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/Language-Attestation-Form.pdf

5. **Member Grievance and Appeal Form**

   https://www.valleyhealthplan.org/members/member-materials/grievances/grievance-form

6. **Potential Quality Issue Reporting Form**

   https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/Potential-Quality-Issue-Reporting-Form.pdf

7. **Prescription Drug Prior Authorization Request Form**

   https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/Prescription-Drug-Prior-Authorization-Request-Form.pdf

8. **Provider Dispute Form**

   https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/Provider-Dispute-Form-Final.pdf

9. **Valley Express Access Request Form**

   https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/ve-ext-access-req-frm.pdf

Printable forms are found in the Appendix. Links to fillable online versions can be found below.

<u>Resources:</u>

10. <u>**Audit Tools**</u>

    a. <u>**Sample Behavioral Health Office Audit Tool**</u>

        https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/Behavioral-Health-Office-Audit-Tool.pdf

    b. <u>**Sample Medical Clinic Office Audit Tool**</u>

        https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/Medical-Clinic-Office-Audit-Tool.pdf

    c. <u>**Sample Medical Records Audit Tool**</u>

        https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/documents/P-MedicalRecordAuditTool-EN-041822-QM.pdf

4. <u>**Members Rights and Responsibilities**</u>

        https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/Members-Rights-and-Responsibilities.pdf

5. <u>**Prior Authorization Guidelines**</u>

        https://www.valleyhealthplan.org/sites/g/files/exjcpb771/files/VHP-Prior-Authorization-Guidelines.pdf

Valley Health Plan

Appendix

If you choose to have a person be your representative to communicate with Valley Health Plan (VHP) on your behalf, complete section 1-3 below. Your personal representative may file a grievance or appeal on my behalf, and may use, receive, disclose your Protected Health Information.

Section 1 – Appointment of Representative
To be completed by the Member or Minor's parent/guardian.

Name of Member:_____

Member ID:_____ Date of Birth:_____

Telephone Number:_____

Address:_____

Name of Minor's parent/guardian:_____

Signature of Member or Minor's parent/guardian:_____

Date:_____

Section 2 – Authorized Use and/or Disclosure
☐ **Check this box to acknowledge that you have read each condition.**

- I authorize the representative to make any request, file and obtain appeals and grievances information, receive any notice in connection with my appeal or health care services in my place.
- I acknowledge that my authorization is voluntary. I understand that I may revoke this appointment at any time by giving written notice to VHP Member Services, 2480 N. First Street Suite 160, San Jose, CA 95131. I understand that the source of medical information about me may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization form. I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal privacy regulations. I understand I have a right to receive a copy of this authorization.
- I authorize VHP to release any of my medical records from the period (enter Month/Day/Year) _____ to _____ (**If no time period is provided, all records will be made available to the representative**) my appointed representative in order for her or him to act on my behalf and/or my child's behalf in filing a grievance and/or appeal.

This representative designation expires on (enter Month/Day/Year) _____
(If no expiration date is provided, this appointment is in effect until revoked in writing).

Section 3 – Acceptance of Appointment

To be completed by the representative(s).

I (We) hereby accept the above appointment.

Name of Authorized Representative #1: _____

Name of Organization (if applicable): _____

Relationship/Professional Status: _____

Telephone Number: _____

Address: _____

☐My power of attorney for health care decisions or other legal document is

attached (check if applicable)

Signature of Authorized Representative #1: _____

Date: _____

Name of Authorized Representative #2: _____

Name of Organization (if applicable): _____

Relationship/Professional Status: _____

Telephone Number: _____

Address: _____

☐My power of attorney for health care decisions or other legal document is

attached (check if applicable)

Signature of Authorized Representative #2: _____

Date: _____

If you have any questions, please call Member Services at **1-888-421-8444**.
For TTY/TDD users, utilize **711** or send email to **MemberServices@vhp.sccgov.org**.
Please mail or fax the completed form to
Attn: Member Services,
Valley Health Plan
2480 N. First Street Suite 160
San Jose, CA 95131
Fax: 1-408-885-4425.

Date: _____ Member phone number: _____

Member Name: _____ Member ID #: _____

Member contact address: _____

Request received by (mark one): ☐ **Phone** ☐ **Email** ☐ **Letter** ☐ **Fax**

Name of Medical Provider: _____

Provider Address: _____

Provider Phone #: _____ Provider Fax #: _____

Continuity of care services being requested (provide summary): _____

_____

_____

_____

Description of member's problem/condition (Select 1):
☐ **Acute Condition**
Diagnosis: _____

☐ **Serious Chronic Condition**
(for example, severe diabetes or heart disease)
Diagnosis: _____

☐ **Pregnancy**
Expected Due Date: _____
Name of Hospital for Delivery: _____

☐ **Terminal Illness**
Diagnosis: _____

☐ **Care of a Child under 3 years.**
Is there a medical diagnosis other than routine care pediatric care please provide:

_____

☐ **An already scheduled surgery or other procedure**
(for example, knee surgery or colonoscopy).
Date of Procedure: _____
Name of Hospital: _____

Medical records provided and attached? ☐ Yes ☐ No

Form Received by: _____   Date received: _____

Sent to UM: ☐ Yes ☐ No   Date Sent: _____

AIDS/ HIV ATTESTATION QUESTIONS

To ensure that standing referrals are granted only to providers who have demonstrated expertise in treating AIDS and HIV, please select the appropriate answer(s) to the questions listed below:

☐ YES - I *do* wish to be designated as an HIV/AIDS *PCP*

☐ NO - I *do not* wish to be designated as an HIV/AIDS *PCP*

☐ YES - I *do* wish to be designated as an HIV/AIDS Specialist based on the criteria below:

- I am certified as an "HIV Specialist" by the American Academy of HIV Medicine (AAHIVM) (please attach certification copy with attestation) *OR*

- I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine by a member board of the American Board of Medical Specialties; *OR*

☐ I am board certified in Infectious Disease and in the past 12 months have clinically managed at least 25 HIV patients and completed 15 hours of category 1 CME in HIV Medicine, five hours of which was related to antiretroviral therapy; *OR*

☐ In the past 24 months I have provided clinical management of 20 HIV patients, and in the past 12 months have completed board certification in Infectious Disease; *OR*

☐ In the past 24 months I have provided clinical management of 20 HIV patients, and in the past 12 months have completed 30 hours of Category 1 CME in HIV Medicine; *OR*

☐ In the past 24 months I have clinically managed at least 20 HIV patients, and in the past 12 months have completed 15 hours of category 1 CME in HIV Medicine and successfully completed the HIV Medicine Competency maintenance Examination administered by the American Academy of HIV Medicine (AAHIVM)

I attest to the best of my knowledge; the above information can be supported by documentation (if required)

Physician Name (print): _____ License #: _____

Physician Signature: _____ Date: _____

✍ Sign

(select: _____ *[top of document] to add signature please)*

Language Capability Attestation (Disclosure) Form

In Accordance with, California Health and Safety Code Section 1300.67.04 of the Language Assistance Program Regulations, Valley Health Plan (VHP) needs to identify within its provider network those contracted providers who are themselves bilingual or who employ other bilingual providers and/or office staff, based on language capability attestation forms signed by the bilingual providers and/or office staff, attesting to their fluency in languages other than English. Such individuals shall have proficiency in health care terminology and concepts relevant to health care delivery systems in the language other than English as well as English, in addition to education and training in interpreter ethics, conduct and confidentiality.

A Separate Form Should be Submitted for Each Location.		
Provider or Clinic:		
Office Address:		
City:	**State:**	**Zip:**
Phone Number:	**Fax Number:**	
NPI Number:		
Email:		

Are you and/or any of your office staff able to provide services in a language other than English? **Yes** ☐   **No** ☐

If "Yes", please indicate what language(s): _____

Please specify what capabilities you have for providing assistance in other languages (i.e. second language, office

staff,etc.…). Attach additional forms if needed to include all applicable staff names AND applicable office location.

_____   _____   _____
Employee Name   Title   Description of capabilities
_____   _____   _____
Employee Name   Title   Description of capabilities
_____   _____   _____
Employee Name   Title   Description of capabilities
_____   _____   _____
 Employee Name   Title   Description of capabilities

I hereby attest that the answers given by me to the foregoing questions and statements made are true and correct and complete in all requests, and understand that if any changes occur in the availability or the above I must notify VHP within 30 days of the change.

Provider Signature: Date:

Please E-mail, mail, or fax the completed form to:

Valley Health Plan
Attn: Language Assistance Program
2480 North First Street Suite #160, San Jose, CA 95131
Memberservices@vhp.sccgov.org
| Phone: 1.888.421.8444 | Fax: 1.408.885.4425 |

Page 1 out of 1

Member Grievance and Appeal Form

Phone: **1-888-421-8444** Fax: **1-408-885-4425**

2480 N. First Street, Suite 160, San Jose, CA 95131

This form is optional. Valley Health Plan can help you fill out this form. You may also file a grievance verbally by calling us at **1-888-421-8444**, 9:00 a.m. to 5 p.m. (PST), Monday – Friday, TTY/TDD should utilize **711** or send email to MemberServices@vhp.sccgov.org. Someone will contact you by phone when this form is received. We will assist you in any way we can and answer any questions that you have. We can help you in any language.

Member Contact Information

Member Name:

Member ID: _____ **Date of Birth:**

Member Address:

Daytime phone number: _____ **Evening phone number:**

Email: _____ **Gender:** ☐ **Male** ☐ **Female** ☐ **Other**

Contact Information for Guardian or Non-Grieved Party

Name of guardian or individual filling, if different from member:

Relationship: _____ **Contact number:**

Email:

Explanation of Issue

Describe the problem in detail:

What would you like someone to do about the problem?

Will you need language assistance? ☐ **Yes** ☐ **No** **If yes, language preference***:*

Do you require medical attention within the next three days or are you in severe pain? ☐ **Yes** ☐ **No**

Date Member filled a grievance with another entity, if applicable:

Is this grievance related to the termination of medical coverage? ☐ **Yes** ☐ **No**

> **If yes, provide date Member received notice that coverage was or will end:**

Please provide any supporting documents with this form, such as plan notice(s) and correspondence(s), billing statements, and proof of payment.

Signature*: _____ **Date:**

*If signed by somebody other than the Member, a Personal Representative (PR) Form is required.

Page 1 out of 2

The Department of Managed Health Care requires Valley Health Plan to inform you of the following:

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 **1-888-421-8444** 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 (**1-888-466-2219**) and a TDD line (**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.

Valley Health Plan – Potential Quality Issue

Reporting Form

Confidential

MEMBER INFORMATION

CALL DATE: **NAME:**   **VHP ID #:**

DATE PQI SENT TO QM: **SEX:**

COVERAGE TYPE: **DATE OF BIRTH:**

DATE OF INCIDENT: **CALL TYPE:**

PROVIDER/SERVICE AREA INFORMATION

PROVIDER: **LOCATION/DEPT:**

PROVIDER GROUP:

COMPLAINT DETAILS

DESCRIPTION:

This communication is intended only for the purpose of reporting a Potential Quality Issue to the VHP Quality Management Department. Secure email to: *VHPQMImprovement@vhp.sccgov.org* or FAX to: (408) 947-5849.

The information is confidential. Dissemination, distribution or copying is strictly prohibited.

Please refer to Policy: QM 2.0 - Identifying, Defining, Processing and Resolution of Potential Quality Issues (PQIs) and Quality Issue Determination.

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name: _____ **Plan/Medical Group Phone#: (_____)_____**

Plan/Medical Group Fax#: (855 **)** 878-9210 _____ 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 Circle unit of measure Height (in/cm): _____ Weight (lb/kg): _____ 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:

Requestor (if different than prescriber):	Office Contact Person:
NPI Number (individual):	Phone Number:
DEA Number (if required):	Fax Number (in HIPAA compliant area):

Email Address:

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 Auth Number (if known):_____

☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:
☐ Patient's Home ☐ Long Term Care
☐ Physician's Office ☐ Home Care Agency ☐ Other (explain):_____
☐ Ambulatory Infusion Center ☐ Outpatient Hospital Care

Revised 12/2016

Form 61-211

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 medications for this condition? ☐ YES (if yes, complete below)   ☐ NO

Medication/Therapy (Specify Drug Name and Dosage)	Duration of Therapy (Specify Dates)	Response/Reason for Failure/Allergy

2. List Diagnoses:	**ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.

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

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:_____

Provider Dispute Form

Claims, Medical, and Administrative Disputes
Phone: 1.408.885.7380

Providers may complete this form to dispute a VHP claim denial or an authorization denial.

Date:

- Fields with an asterisk (*) are required in order for VHP to process.*
- Provider should specify and attach any additional information or documentation to support the description of the dispute.
- For multiple like disputes please use Multiple Like dispute form.
- If provider is appealing on behalf of the member, an AOR form is required.
- For reconsiderations or retro-authorization requests, please submit authorization request direct to:

   Valley Health Plan Attention: Utilization Review Department
   FAX: 408.885.4875 or VHP Contracted Providers may use on-line submission through Valley express

Provider Information:

*Provider NPI:	*Provider Tax ID:
*Provider Name:	
*Provider Address:	

Provider Type: ☐ MD ☐ Mental Health   ☐ Hospital   ☐ ASC   ☐ SNF

☐ DME ☐ Rehab   ☐ Home Health   ☐ Ambulance ☐ Other: _____

Dispute Type: ☐ Claims   ☐ Contract Dispute

   • Underpayment/Overpayment/Timely Filing/EOB
   ☐ Appeal of Medical Necessity / Utilization Management Decision (*Authorization reference)
   ☐*Authorization Number ☐Other:

Claim Information: _____

*Patient Name:	*Date of Birth:
*Member ID #:	Patient Account Number:
*VHP Claim #:	*Date of Service:
*Original Claim Amount Billed:	Original Claim Amount Paid:

*Dispute Description:

Attachments: ☐ Medical Records   ☐ Authorization / Referral   ☐ COB / EOB
       ☐ Proof of Timely Filing   ☐ Proof of Eligibility   ☐ AOR
       ☐ Other: ☐ Invoice / Bill

Expected Outcome:

Contact Information:

*Contact Name: _____ Title: _____ Phone Number: _____

*Signature: _____ Date: _____ *Fax Number: _____

*Mailing Address: _____

*Email _____

Page 1 out of 2

Date: _____

	Multiple "LIKE" claims are for the same provider and dispute type but different members. Fields with an asterisk (*) are required. If filing multiple "LIKE" claims please complete <u>Provider Dispute Form</u> and submit online.

*Provider Name: _____   NPI Number: _____

 *Provider Address: _____

	*Patient Name		*Date of Birth	*Health Plan ID Number	*Original Claim Number	*Date of Service	*Original Claim Amount Billed	Original Claim Amount Paid
	Last	First						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

*Contact Name: _____   Title: _____   Phone Number: _____

 *Signature: _____   Date: _____   *Fax Number: _____

*Mailing Address: _____

 *Email: _____

Welcome to Valley Express (VE)

Valley Express is Valley Health Plan's (VHP) Authorization and Referral data system. By signing this document, the individual signifies that the County's User Responsibility Statement has been read and its contents understood. The User Responsibility Statement establishes a uniform, Santa Clara County-wide set of minimum responsibilities associated with being granted access to County information systems and/or County networks.

We encourage you to sign up with Valley Express for direct system access to generate authorizations and referrals for your VHP members, as well as for any patients you wish to refer to SCVMC.

Please review and make copies of the following documents for each designated staff in need of Valley Express access.

> User Responsibility Statement
> General Code of Responsibility
> Acknowledgement of Receipt for Access to Valley Express

Each individual who will submit authorizations and referrals must complete the "*Acknowledgement of Receipt for Access to Valley Express*" form and email to VHP Provider Relations at **VEAccess@vhp.sccgov.org**. Please make sure that the document is legible.

Once approved, you will receive an email with your Valley Express login, password, and link to access the Valley Express "live" system.

If you have any questions or would like to request a training on how to use Valley Express, please contact VHP Provider Relations at **408.885.2221**.

Thank you,

VHP Provider Relations

SANTA CLARA COUNTY INFORMATION TECHNOLOGY
USER RESPONSIBILITY STATEMENT INSTRUCTIONS

In May 1995 the Board of Supervisors charged each County organization with the responsibility for ensuring that all County employees had read and signed a statement of responsibility concerning use of the County's networks and information systems. The resulting County-wide User Responsibility Statement is intended as a *minimum* statement of User responsibility, and individual County Agencies and Departments may require Users to read and sign additional statements to meet any special requirements that apply within their own environments.

- The County User Responsibility Statement must be signed by anyone who might reasonably require access to a County network and/or information system. This includes all County employees, as well as any other individual who needs authorized access for County business purposes. All Users who are allowed to access County resources remotely must also sign an additional attachment specifically related to remote access; this is included as Attachment A of the User Responsibility Statement. In addition, Users who are granted approval to use a personally-owned device for County business must also sign Attachment B of the User Responsibility Statement.

- By signing the Statement or its attachments, Users acknowledge that they have read and understand the contents and that violation of any of the provisions may result in disciplinary action, up to and including termination of employment and/or criminal prosecution.

- If an individual refuses to sign the Statement, the Department can choose to read the Statement to the individual, who will be required to verbally acknowledge understanding of the Statement's contents in the presence of two or more responsible managers. These managers will attest in writing that this reading and verbal attestation of understanding occurred. Failing this verbal acknowledgement of understanding, the involved individual will be denied access to all County information systems and networks.

- Each County organization is responsible for storing and maintaining the signed Statements of its own Users.

- All County organizations shall have their Users re-execute the Statement and/or attachments annually, or whenever there is an update or other change to the Statement or attachments (Department Heads will be notified by the County CIO's office of any updates or changes to the Statement or attachments).

- Each County organization should identify a "User Responsibility Statement Administrator." This is an occasional personnel function that should NOT be filled by a member of the organization's information system support staff. Because it is a

personnel function, a good choice would be an employee in an administrative position who is responsible for other routine personnel issues.

The User Responsibility Statement Administrator is responsible for the following tasks:

1. Identifying employees and other Users within the organization that will need to read and sign the Statement, as well as the relevant attachments.

2. Managing the signing process, including arranging for any briefings to be held in conjunction with Users signing the Statement and attachments.

3. Maintaining the signed Statements and attachments.

4. Ensuring that new employees and other new Users read and sign the basic Statement and any relevant attachments, and that the Department signing process is performed by all Users on an annual basis.

SANTA CLARA COUNTY IT USER RESPONSIBILITY STATEMENT

This User Responsibility Statement establishes a uniform, County-wide set of minimum responsibilities associated with being granted access to Santa Clara County information systems and/or County networks. A violation of this Statement may lead to disciplinary action, up to and including termination.

Definition

County information systems and networks include, but are not limited to, all County-owned, rented, or leased servers, mainframe computers, desktop computers, laptop computers, handheld devices (including smart phones, wireless PDAs and Pocket PCs), equipment, networks, application systems, data bases and software. These items are typically under the direct control and management of County information system support staff. Also included are information systems and networks under the control and management of a service provider for use by the County, as well as any personally-owned device that a User has express written permission to use for County business purposes.

County -owned information/data is any information or data that is transported across a County network, or that resides in a County-owned information system, or on a network or system under the control and management of a service provider for use by the County. This information/data is the exclusive property of the County of Santa Clara, unless constitutional provision, State or Federal statute, case law, or contract provide otherwise. County-owned information/data does not include a User's personal, non-County business information, communications, data, files and/or software transmitted by or stored on a personally-owned device if that information/data is not transported across a County network or does not reside in a County-owned information system or on a network or system under the control and management of a service provider for use by the County.

A *mobile device* is any computing device that fits one of the following categories: laptops; Personal Digital Assistants (PDAs); handheld notebook computers and tablets, including but not limited to those running Microsoft Windows CE, PocketPC, Windows Mobile, or Mobile Linux operating systems; and "smart phones" that include email and/or data storage functionality, such as BlackBerry, Treo, Symbian-based devices, and iPhones. Note that the category "Mobile Device" does not include devices that are used exclusively for the purpose of making telephone calls.

A *public record* is any writing, including electronic documents, relating to the conduct of the people's business as defined by Government Code section 6252.

"*Remote access*" is defined as any access to County Information Technology (IT) resources (networks or systems) that occurs from a non-County infrastructure, no matter what technology is used for this access. This includes, but is not limited to, access to County IT resources from personal computers located in User's homes.

Users includes County employees who are on the permanent County payroll, as well as any other individual who has been authorized to access County networks and systems.

Key Points

1.**General Code of Responsibility**

The following General Code of Responsibility defines the basic standards for User interaction with County information systems and networks. All Users of County information systems and networks are required to comply with these minimum standards.

1.1   Users are personally responsible for knowing and understanding the appropriate standards for User conduct, and are personally responsible for any actions they take that do not comply with County policies and standards. If a User is unclear as to the appropriate standards, it is that User's responsibility to ask for guidance from appropriate information systems support staff or Department management.

You are responsible for your own behavior.

If you're unclear about a security standard, it's your responsibility to ask for guidance.

1.2   Users must comply with basic County standards for password definition, use, and management.

You must comply with County password standards.

1.3   With the exception of County-owned and approved devices issued to specific authorized County users, only authorized information systems support staff may attach any form of computer equipment to a County network or system unless express written permission to do so is given by Department management. This includes, but is not limited to, attachment of such devices as laptops, PDAs, peripherals (e.g., external hard drives, printers), and USB storage media.

Don't attach computer equipment of any kind to County systems or networks without permission.

1.4   The use of personally-owned USB storage media on any County computer system is prohibited. All such devices must be County-owned, formally issued to the User by the Department, and used only for legitimate County business purposes.

Use only County-owned and issued USB storage media.

1.5   Connecting County owned computing equipment, including USB storage media, to non-County systems or networks is prohibited unless express written permission has been given by Department management. This formal approval process ensures that the non-County system or network in question has been evaluated for compliance with County security standards. An example of a

Don't attach County equipment of any kind to non-County computers or networks.

permitted connection to a non-County system or network would be approved connection of a County issued laptop to a home network.

1.6 No User, including information systems staff, may install, configure, or use any device intended to provide connectivity to a non-County network or system (such as the Internet), on any County system or network, without express written permission. All such connections must be approved in writing by the County Chief Information Officer (CIO) or designee. If authorized to install, configure or use such a device, the User must comply with all applicable County standards designed to ensure the privacy and protection of data, and the safety and security of County systems.

Don't install or activate communication devices, such as modems, on County computers or networks.

1.7 The unauthorized implementation or configuration of encryption, special passwords, biometric technologies, or any other methods to prevent access to County resources by those individuals who would otherwise be legitimately authorized to do so is prohibited.

Don't use encryption except when directed to do so.

1.8 Users must not attempt to elevate or enhance their assigned level of User privileges unless express written permission to do so has been granted by Department management. Users who have been granted enhanced privileges due to their specific jobs, such as system or network administrators, must not abuse these privileges and must use such privileges only in the performance of appropriate, legitimate job functions.

Don't attempt to enhance your assigned user privileges.

1.9 Users must use County-approved authentication mechanisms when accessing County networks and systems, and must not deactivate, disable, disrupt, or bypass (or *attempt* to deactivate, disable, disrupt, or bypass) any security measure or security configuration implemented by the County.

Don't attempt to disable or bypass County login procedures.

1.10 Users must not circumvent, or attempt to circumvent, legal guidelines on software use and licensing. If a User is unclear as to whether a software program may be legitimately copied or

Follow the terms of all software licensing agreements.

installed, it is the responsibility of the User to check with Department management or information systems support staff.

1.11 All software on County systems must be installed by authorized systems support staff. Users may <u>not</u> download or install software on any County system unless express written permission has been obtained from Department management or authorized system support staff.

Don't download or install software without permission.

1.12 Loss or theft of County-owned computer equipment, or of personally-owned computer equipment that has been approved for use in conducting County business, is to be reported immediately to the designated Department management, administrative, or systems support staff. Users are also expected to be aware of security issues, and are encouraged to report incidents involving breaches of security, such as the installation of an unauthorized device, or a suspected software virus.

Immediately report the loss or theft of computer equipment, and also report any suspected security incidents.

1.13 Users must respect the sensitivity, privacy and confidentiality aspects of all County-owned information. In particular:

- Users must not access, or attempt to access, County systems or information unless specifically authorized to do so, *and* there is a legitimate business need for such access.

Don't access computers or data unless such access is related to your job.

- Users must not allow unauthorized individuals to use their assigned computer accounts; this includes the sharing of account passwords.

Don't share your user accounts or passwords with anyone.

- Users must not knowingly disclose County information to anyone who does not have a legitimate need for that information.

Don't share information with someone not entitled to have it.

- Users must take every precaution to ensure that all information classified as either Confidential or Restricted (or an equivalent classification) is protected from disclosure to unauthorized individuals.

Protect sensitive data from those not authorized to see it.

Key Points

- Users must not make or store paper or electronic copies of information unless it is a necessary part of that User's job.

Don't make copies of information unless this is required by your job.

1.14 Users must respect the importance of County-owned systems and data as a valuable asset, and should understand that any data stored or processed on any County computer, or transmitted over any County network, is County property. In particular:

- Users must not change or delete data or information unless performing such changes or deletions is a legitimate part of the User's job function.

Don't change or delete data unless doing so is part of your job.

- Users must avoid actions that might introduce malicious software, such as viruses or worms, onto any County system or network.

Don't introduce computer viruses onto County computers.

- A User who leaves employment with the County must not retain, give away, or remove any County data or document from County premises, other than information provided to the public or copies of correspondence directly related to the terms and conditions of employment. All other County information in the possession of the departing User must be returned to the User's immediate supervisor at the time of departure.

When leaving County employment, don't take County data with you.

1.15 Users should be aware that electronic information transported across any County network, or residing in any County information system, is potentially subject to access by County technical support staff, other County Users, and the general public. Users should not presume any level of privacy for data transmitted over a County network or stored on a County information system.

You should have no expectation of privacy for electronic data stored on County computers.

1.16 Users must respect all intellectual property rights, including but not limited to rights associated with patents, copyrights, trademarks, trade secrets, proprietary information, and confidential

Respect all intellectual property rights associated with data that you deal with while doing your job.

information belonging to the County or any other third party.

1.17 All information resources on any County information system or network are the property of the County and are therefore subject to County policies regarding acceptable use. No User may use any County-owned network, computer system, or any other County-owned device or data for the following purposes:

- Personal profit, including commercial solicitation or conducting or pursuing their own business interests or those of another organization

Don't use County computers to conduct your personal business.

- Unlawful or illegal activities, including downloading licensed material without authorization, or downloading copyrighted material from the Internet without the publisher's permission

Don't use County computers for illegal activities.

- To access, create, transmit, print, download or solicit material that is, or may be construed to be, harassing or demeaning toward any individual or group for any reason, including but not limited to on the basis of sex, age, race, color, national origin, creed, disability, political beliefs, organizational affiliation, or sexual orientation, unless doing so is legally permissible and necessary in the course of conducting County business

Don't create or send demeaning or harassing material.

- To access, create, transmit, print, download or solicit sexually-oriented messages or images, or other potentially offensive materials such as, but not limited to, violence, unless doing so is legally permissible and necessary in the course of conducting County business

Don't view, download, or send pornography or other potentially offensive materials.

- Knowingly propagating or downloading viruses or other malicious software

Don't download or transmit malicious software.

- Disseminating hoaxes, chain letters, or advertisements

Don't send chain letters.

1.18   Users that are employed by, or are otherwise associated with, a HIPAA impacted Department, are responsible for understanding and carrying out their responsibilities and duties as identified in the County HIPAA policies and procedures training, and other HIPAA-related materials that may be distributed from time to time.

Handle all protected health information according to HIPAA regulations.

2.**Internet and Email**

The following items define the basic standards for use of County Internet and email resources. All Users of County information systems and networks are required to comply with these minimum standards.

2.1   In general, Users must not use County systems or networks for personal activities. However, reasonable incidental (*de minimus*) personal use of County resources, such as Internet access and email, is allowed as long as such use does not violate the County's acceptable use policies, and does not interfere with the performance of work duties or the operation of the County's information systems. If a User is unclear as to what is considered appropriate incidental personal use, it is the responsibility of the User to ask for guidance from Department management.

Limit personal use of County computers.

2.2   When conducting County business, Users may not configure, access, use, or participate in any Internet-based communication or data exchange service unless express written permission has been given by Department management. Such services include, but are not limited to, Internet Instant Messaging (such as AOL Instant Messaging), Internet email services (such as Hotmail and Gmail), peer-to-peer networking services (such as Kazaa), and social networking services (such as blogs, MySpace, Facebook and Twitter).

Don't use Internet email or data exchange services (such as FaceBook, MySpace, or other social networking sites) to conduct County business.

2.3   It is the User's responsibility to become familiar with the specific County policies, procedures, and guidelines associated with the use of Internet-based communication and data exchange services. Users who have been granted permission to use an Internet-based communication or data exchange service for conducting County business are expected to adhere to all relevant County policies, procedures, and guidelines associated with the use of these services.

You are responsible for understanding County guidelines for using Internet data exchange services, such as social networking sites.

2.4   Users are responsible for understanding and following the County's policy with respect to the retention of email messages, including immediately deleting non-business related email messages once these messages have been read.

Follow County standards for retaining and deleting email messages.

2.5   Users may not use an internal County email account assigned to another individual to either send or receive email messages.

Don't use anyone else's email account.

2.6   Users may not configure their County email account so that it automatically forwards messages to an external Internet email system unless express written permission has been given by the Department Head. When automated forwarding is used, it must be for legitimate business purposes only, and is to be implemented with the User's full understanding of, and willingness to accept responsibility for, the associated risks for disclosure of sensitive information.

Don't automatically forward County email to an Internet email system.

3. Remote Access

The following items define the basic standards for remote access to County information systems and networks. All Users of County information systems and networks are required to comply with these minimum standards. Users actually granted remote access privileges must sign the statement provided as Attachment A.

3.1   All remote access to County resources must be via the secure, centralized, County-controlled mechanisms and technologies approved by the County CIO or designee, and installed by authorized County systems support staff. Users are not permitted to implement, configure, or use any remote access mechanism other than the County-owned and managed remote access systems that have been formally approved and implemented by authorized system support staff.

Use only existing, approved County remote access systems.

3.2   Written approval for use of County remote access mechanisms is to be granted to a specific User by the appropriate Department Head or designee. Remote access to County resources will be implemented on a case-by-case basis based on job-related necessity, and only for those Users that have read and signed both the County's general User Responsibility Statement and the Remote Access agreement (Attachment A).

Get approval for all remote access to County systems.

3.3   Remote access sessions may be monitored and/or recorded, and complete information on the session logged and archived. Users have no right, or expectation, of privacy when remotely accessing County networks, systems, or data. Audit tools may be used to create detailed records of all remote access attempts and remote access sessions, including User identifier, date, and time of each access attempt.

Remember that remote access sessions may be monitored and/or recorded.

3.4   All computer devices used to access County resources from a remote location must be configured according to County-approved security standards. These include approved, installed, active, and current: anti-virus software, software or hardware-based firewall, full hard drive encryption, and any other security software or security-related system configurations that are required and approved by the County.

Computers used for remote access must be configured according to County standards.

3.5   Users that have been provided with a County-owned device intended for remote access use, such as a laptop or other Mobile Device, will

take all reasonable measures to ensure that the device is protected from damage, access by third parties, loss, or theft. Loss or theft of such devices must be reported immediately to designated Department management or support staff.

Take measures to prevent the loss or theft of County-owned Mobile Devices used for remote access, and report loss or theft of such devices immediately.

3.6   Users will practice due diligence in protecting the integrity of County networks, systems, and data while remotely accessing County resources, and will immediately report any suspected security incident or concern to their Department management and IT support staff.

Take appropriate measures to protect County computers and data when using remote access.

3.7   Remote access sessions are subject to all other relevant County IT security policies and standards, including Local User Authentication (passwords), Data Classification, Internet Use, and Email.

When using remote access, continue to follow all County security policies.

4. Personally-Owned Devices

The following items define the basic standards for the use of personally-owned devices to conduct County business. All Users of County information systems and networks are required to comply with these minimum standards. Users actually granted the privilege of using a personally-owned device to conduct County business must also sign the statement provided as Attachment B.

Note that in the case of Mobile Devices, the following provisions apply only to those devices that include email and/or data storage capability (such as BlackBerry devices and other "smart" phones), and do not apply to devices that are used strictly for the purpose of making telephone calls.

4.1   Use of personally-owned devices to conduct County business is prohibited unless express written permission is obtained from both the Department Head and IT Manager. If the User in question is a Department or Agency Head, express written permission must also be

Use of a personally-owned device to conduct County business requires approval.

obtained from the County Chief Information Officer or designee. The use of personally-owned devices to conduct County business is a privilege, not a right, and employment at the County does not automatically guarantee the granting of this privilege.

4.2   The personally-owned device in question must use existing, County-approved and County-owned access/authentication systems when accessing County resources. Installation by Users of any hardware, software, or network interface components that provide unauthorized network connectivity, either wired or wireless, is prohibited.

If you are allowed to use your own computer or mobile device for County business, you must still use County-approved user login procedures.

4.3   The User shall allow the County to configure personally-owned devices as appropriate to meet security requirements, including the installation of specific security software that is mandated by County policy. When reasonably possible and practical, the County shall strive to provide a minimum of 24-hour notice to the User before configuring the personally-owned device. While the device is in the County's possession, the County shall not access, alter, retrieve or delete the User's personal information, communications, data, software or files stored on the device unless (a) it is reasonably necessary to do so to configure the device to meet security requirements, or (b) the User agrees to the specific access, alteration, retrieval or deletion.

You must allow authorized IT staff to configure, and periodically update, security software on any personally-owned device used to conduct County business.

4.4   Users authorized to use a personally-owned device must follow designated Department procedures for ensuring that software updates and patches are applied to the device according to a regular, periodic schedule. All software installations and updates are subject to verification by management-designated Department staff.

Follow Department procedures for updating and patching software on personally-owned devices.

4.5   Users have no expectation of privacy with respect to any County-owned communications, information, or files on any personally-owned device. Users agree that, upon request, the County may immediately access any and all work-related or County-owned communications, information or files stored on these devices, in order to ensure compliance with County policies. Except as otherwise provided in this policy or as required by law, the County shall not access any of the User's personal information, communications, data or files on the User's personally-owned devices.

The County has the right to access County data on any personally-owned device used to conduct County business.

4.6   Upon reasonable suspicion that a User has failed to comply with County policy, the County may search and access communications, information, data, or files on the personally-owned device that are reasonably related to the County's suspicion and interest in conducting the search. Any such search and access will take place with a goal of returning the device within 48 hours, if reasonably possible. The search and access shall be conducted in the presence of the User and/or the User's representative when requested by the User. At the request of the Department and with reasonable notice (not to exceed 48 hours), the User must provide a copy of all work- related or County-owned communications, information, or files stored on the personally-owned device. If the personally-owned device contains any information which is subject to lawful privilege (such as attorney-client or work product), that device shall be searched by Department representatives who are entitled to view the information, so that the privilege is not violated.

The County may search a personally-owned device if there is a suspicion that County policy has been violated.

4.7   If a user is contacted on a personally-owned device by someone from the County conducting County business, and the User has not obtained

permission to conduct County business with that personally-owned device, then the County may not access that device regarding that User-received communication other than through legally permissible methods such as a subpoena, request for voluntary disclosure, etc. The preceding sentence shall not limit the County's right to direct a User to disclose the communication at issue upon reasonable notice.

The County will not require you to allow access to your personally-owned device for unsolicited, incoming County communications if that device has not been approved for use in conducting County business.

4.8   The User shall adhere to all relevant County security policies and standards, just as if the personally-owned device were County property. This includes, but is not limited to, policies regarding password construction and management, physical security of the device, device configuration, and hard drive sanitization prior to disposal. This does not restrict the User's personal use of the device so long as that personal use does not include or result in (a) the User's failure to adhere to all relevant County security   policies and standards, or (b) the breach of the County's security policies or standards.

Even when using your own computer or other device for County business, you must still follow all County security policies.

Under most circumstances, you can continue to use an approved device for personal use as well as County business.

4.9   The User will make no modifications of any kind to operating system configurations implemented by the County on the device for security purposes, or to any hardware or software installed on the device by the County, without the express written permission of the County CIO's Office.

Don't modify any security configuration settings or security software on your computer.

4.10   The User must treat the device and the work-related or County-owned communications, information or files it contains as County property. The User must not allow access to or use of any work-related or County-owned communications, information, or files by individuals who have not been authorized by the County to access or use that data.

Treat any personally-owned device used for County business as if it were County-owned.

4.11   The User must immediately report to

The designated Department management or support staff any incident or suspected incident of unauthorized access and/or disclosure of County resources, data, or networks that involve the device, including loss or theft of the device.

Immediately report the loss or theft of a personally-owned device that has been used for County business.

Acknowledgement of Receipt

This Acknowledgement hereby incorporates the main body of the User Responsibility Statement. Attachments A and B are additional signature pages that apply <u>only</u> to those individuals that have been granted either remote access privileges (Attachment A) or permission to use a personally-owned device (Attachment B). These Attachments should only be signed if either of these conditions apply.

The User should understand that the County's failure to enforce any provision of this Statement does not mean that the County will not enforce that or any other provision in the future. The User should also understand that if a clause, sentence or paragraph of this Statement is determined to be, invalid by a Court or County commission, this does not affect the validity of any other portion of the Statement.

By signing below, I acknowledge that I have read and understand all sections of the County of Santa Clara's User Responsibility Statement. I also acknowledge that violation of any of its provisions may result in disciplinary action, up to and including termination of employment and/or criminal prosecution.

If at any time, I have questions or doubts, or I feel ambivalent or unclear on any matter related to IT security and/or data confidentiality, I understand that it is my responsibility to request clarification from my supervisor or other appropriate manager before taking any action.

All Users must sign this Acknowledgement; Users with permission to use Remote Access should also sign Attachment A, and Users with permission to use personally-owned devices must complete and sign Attachment B.

Violation of any of the provisions in this User Responsibility Statement may result in disciplinary action.

It is your responsibility to ask for clarification if you don't understand any aspect of the County IT security policy.

Please Email to VHP Provider Relations at VEAccess@vhp.sccgov.org
On subject line of email enter Provider name and NPI
<u>**Acknowledgement of Receipt for Access to Valley Express Online Authorization System**</u>

This statement hereby incorporates Attachment A – Board of Supervisors Approved Policy on "E-Mail", Attachment B – Board of Supervisors Approved Policy on "Internet Usage", and Attachment C – Additional Responsibilities for Users Accessing County IT Assets from a Non-County (Remote) Locations. Attachment C only applies to individuals that have been granted remote access privileges and should only be signed by those specific individuals. By signing this Statement, the following individual signifies that the County's User Responsibility Statement has been read and its contents understood. The signer also acknowledges that violation of any of its provision may result in disciplinary action, leading up to and including termination and/or criminal prosecution.

The signer also acknowledges that this Statement will still be in effect following any transfer to another County Agency or Department, and that all of its provisions will continue to apply to the undersigned.

Please Print Legibly.

User Signature: _____

Print Name (legibly): _____

Organization/Site: _____

Individual or Group NPI: _____

Name of Clinician (Independent Clinics): _____

Phone Number: _____

Email Address: _____

Date Signed: ___0_____

Supervisor Name: _____

Supervisor Signature: _____

Date Signed: __0_____

SUBMISSION				
VHP ONLY (For Internal Use)				
CA TICKET #	EFF/CHG DATE	TERM DATE	ANALYST	AUTHORIZED APPROVER

Provider Relations | 2480 N. First Street, Suite 200, San José, CA 95131 | Tel: 408.885.2221 | Fax: 408.793.6648

Behavioral Health Office
Audit Tool

Practitioner Name:

Review Date:

Practitioner Address:

Reviewer Name/Title:

Contact Person/Title:

Visit Purpose
□ Monitoring
□ Corrective Action Plan -Follow Up
□ Other

Provider Type	
□ Psychiatrist	□ LMFT
□ LCSW	□ Psychologist
□ Other	

Site Score			
1. Access/Safety	19	/	19
2. Office Management	18	/	18
3. Medication	5	/	5
4. Behavioral Education	1	/	1

Office Type	
□ BH Office	□ Other

	43	/	43
Total	**100%**		
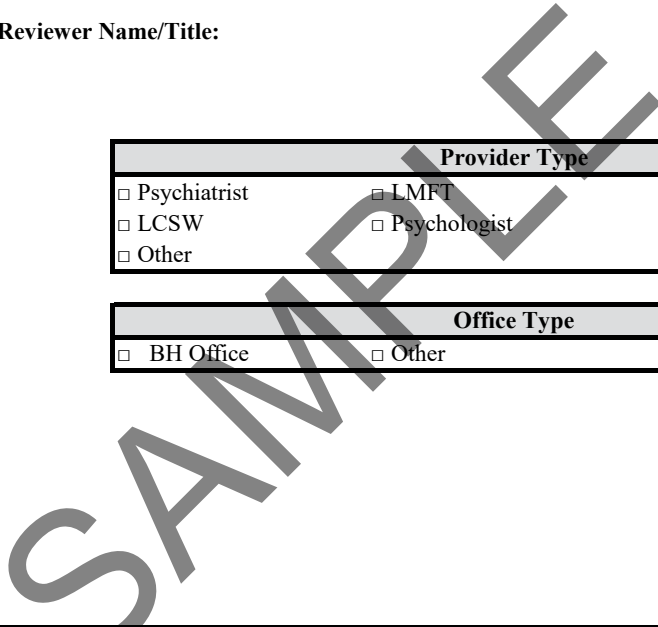
Performance Standard
□ **Pass**: 90% met critical elements
□ **Pass**: 90% did not meet a critical element *
□ **Not Pass**: Below 89%
□ CAP Required
□ Other Follow-Up   *Critical elements - these are identified with an asterisk and the number is bolded

Scoring Procedure
1) Site score is total point only. The site score is one (1) or zero (0), there are not half points (0.5) given.

2) Add points given in each section
3) Add total points given in each sections.
4) Adjust score for "N/A" criteria (if needed). Subtract "N/A" points from _____total points possible.
5)Divide total points given by _____ or by "adjusted" total rate.
6) Multiply by 100 to get the performance score.
7) **Calculate**

$$\underline{\hspace{2cm}} \div \underline{\hspace{2cm}} = \times 100 = \underline{\hspace{2cm}}$$

Point   Time/Adjusted   Performance
Given   Points   Standard

Section		Site Access/Safety Audit Criteria	Yes	No	N/A	Audit Score	Score	Comment
A.		**Behavioral Health Office is accessible and useable by individuals with physical disabilities.**						
A.	1	Clearly marked (blue) curb or sign designating disabled-parking space near assessable primary entrance.	x			1	1	
A.	2	Pedestrian ramps have a level landing at the top and bottom of the ramp.	x			1	1	
A.	3	Exit doorway openings allow for clear passage of a person in a wheelchair.	x			1	1	
A.	4	Accessible passenger elevator or reasonable alternative for multi-level floor accommodation.	x			1	1	
A.	5	Clear floor space for wheelchair in waiting area and exam room.	x			1	1	
A.	6	Wheelchair accessible restroom facilities or reasonable alternative.	x			1	1	
A.	7	Wheelchair accessible hand washing facilities or reasonable alternative.	x			1	1	
B.		**Behavioral Health environment is maintained in a clean, safe and sanitary condition.**						
B.	1	All patient areas including floor/carpet, walls, and furniture are neat, clean, well maintained and the space allocated for a particular function or service is adequate for the activities performed therein.	x			1	1	
B.	2	Restrooms are clean and contain appropriate sanitary supplies.	x			1	1	
B.	3	Reception areas are provided.	x			1	1	
C.		**Behavioral Health environment is safe for all patients, visitors and personnel.**						
C.	1	Fire safety and prevention.	x			1	1	
C.	2	Emergency non-medical procedures (e.g. site evacuation, workplace violence).	x			1	1	
C.	3	Lighting is adequate in all areas to ensure safety.	x			1	1	
C.	4	Exit doors and aisles are unobstructed and egress (escape) accessible. The facility has stairwells protected by fire doors, if applicable.	x			1	1	
C.	5	*(Critical Element) Exit doors are clearly marked with "Exit" signs.	x			1	1	
C.	6	Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location.	x			1	1	
C.	7	Electrical cords and outlets are in good working condition.	x			1	1	
C.	8	At least one type of firefighter/protection equipment is accessible at all time.	x			1	1	

Reference: California Department of Services, Medi-Cal Care Division   1

D.		Emergency health care.						
D.	1	Behavioral Health practitioner/staff are trained in procedures/action to be carried out in case of medical emergency within the office.	x			1	1	
		Total	19			19	19	

Reference: California Department of Services, Medi-Cal Care Division

2

Section		Office Management Audit Criteria	Yes	No	N/A	Audit Score	Score	Comment
A.		**Behavioral Health Practitioner coverage.**						
A.	1	Provider office hour schedules are posted/available to members. **Provider/s who lack malpractice insurance coverage post the information.**	x			1	1	
A.	2	Arrangement/schedule for after-hours, on-call, weekends, and holiday coverage.	x			1	1	
A.	3	Emergency care instructions/telephone information are in place (911).	x			1	1	
A.	4	Telephone answering machine, voice mail system or answering service is used whenever office staff does not directly answer phone calls and periodically updated.	x			1	1	
B.		**Behavioral Health care services are readily available.**						
B.	1	Appointments are scheduled according to patients' stated clinical needs within the timeliness standards established for Plan members.	x			1	1	
B.	2	Patients are notified of scheduled routine and/or preventive screening appointments.	x			1	1	
B.	3	There is a system in place to follow-up on missed and canceled appointments.	x			1	1	
B.	4	Behavioral Health Practitioner and/or scheduling staff are aware an appointment is to be available within ten (10) business days.	x			1	1	
B.	5	Behavioral Health Practitioner and/or staff are aware wait time in office from registration to seeing Behavioral Health Practitioner is within thirty (30) minutes.	x			1	1	
C.		**There is access to interpreter services for limited-English proficient members.**						
C.	1	Interpreter services are made available.	x			1	1	
D.		**Member Grievance/Complaint processes is established on site.**						
D.	1	Phone number(s) for filing grievance/complaint is available.	x			1	1	
D.	2	Office staffs are knowledgeable on the grievance process.	x			1	1	
F.		**Confidentiality of personal medical information is protected according to State and Federal guidelines**						
E.	1	Medical records are readily retrievable for scheduled member encounters.	x			1	1	
E.	2	Counseling rooms and waiting area safeguards members' right to privacy.	x			1	1	
E.	3	Procedures are followed to maintain the confidentiality of personal member information with medical record whether paper or electronic.	x			1	1	

Reference: California Department of Services, Medi-Cal Care Division

3

E.	4	Medical record release procedures are compliant with State and Federal guidelines.	x			1	1	
E.	5	Storage and transmittal of medical records preserves confidentiality and security.	x			1	1	
E.	6	Medical records are retained for a minimum of 10 years. Pediatric until child is 18 years.	x			1	1	
		Total	18			18	18	

Reference: California Department of Services, Medi-Cal Care Division

4

SAMPLE

Section		Medication Services Audit Criteria	Yes	No	N/A	Audit Score	Score	Comment
A.		**Medication and maintained secured and safe.**						
A.	1	Medications are stored and locked in specifically designated cupboards, cabinets, closets or drawers.	x			1	1	
A.	2	Medications are kept separate from food, cleaning supplies, and other items that may potentially cause contamination.	x			1	1	
A.	3	There are no expired medication on site.	x			1	1	
A.	4	Site has a procedure to check expiration date of all medications.	x			1	1	
A.	5	All stored and dispensed prescription medication are appropriately labeled.	x			1	1	
		Total	5			5	5	

Section		Behavioral Health Education Audit Criteria	Yes	No	N/A	Audit Score	Score	Comment
A.		**Behavioral Health Education services are available.**						
A.	1	Education materials are available as needed.	x			1	1	
		Total	1			1	1	

Comment: Write a comment for all "No" (0 points) and "N/A" scores.

Reference: California Department of Services, Medi-Cal Care Division

5

Purpose: Behavioral Health Office Site Review Guidelines provide standards for the medical record audit, and shall be used for measuring, evaluating, assessing, and making decisions.

Scoring: The audit includes on-site observation and discussion with personnel. Reviewers use reasonable evidence available during the review process to determine if practices and systems on site meet audit/guideline criteria. Pass: 90% or above or Not Pass: below 90%. A corrective action plan will be required even if the pass score is achieved when a critical element was not met. Compliance rates are based on 000 total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Score one point(s) if audit criteria is met. Score zero (0) points if criteria is not met. Do not score partial points for any criteria. Explain all "N/A" and "No" (0 point) items in the comment section of the behavioral health audit tool.

ACCESS/SAFETY

Section A	Behavioral Health Office is accessible and useable by individuals with physical disabilities

3 CCR §504; 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III)

ADA Regulations: Site must meet city, county and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. All facilities designed, constructed; or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992 (28 CFR 35.151). Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs (28 CFR 36.402).

Parking: Parking spaces for persons with physical disabilities are located in close proximity to handicap-accessible building entrances. Each parking space reserved for the disabled is identified by an affixed reflectorized sign posted in a conspicuous place. If provider has no control over availability of disabled parking lot or nearby street spaces, provider must have a plan in place for making program services available to persons with physical disabilities.

Ramps: A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. Any path of travel is considered a ramp if its slope is greater than a 1-foot rise in 20 feet of horizontal run.

Exit doors: The width of exit doorways (at least 32-in.) allows for passage clearance of a wheelchair. Exit doors include all doors required for access, circulation and use of the building and facilities, such as primary entrances and passageway doors. Furniture and other items do not obstruct exit doorways or interfere with door swing pathway. The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route, but may be reduced to a minimum of 32 inches at a doorway.

Elevators: If there is no passenger elevator, a freight elevator may be used to achieve program accessibility if it is upgraded for general passenger use and if passageways leading to and from the elevator are well-lit, neat and clean.

Clear Floor Space: Clear space in waiting/exam areas is sufficient (at least 30-in. x 48-in.) to accommodate a single, stationary adult wheelchair and occupant. A minimum clear space of 60-in. diameter or square area is needed to turn a wheelchair.

Restrooms: Restroom and hand washing facilities are accessible to able-bodied and physically disabled persons. A wheelchair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close. If wheelchair accessible restrooms are not available within the office site, reasonable alternative accommodations are provided which may include a wheelchair accessible restroom located in a nearby office or shared within a building. Sufficient knee clearance space underneath the sink allows for wheelchair users to safely use a lavatory sink for hand washing. A reasonable alternative may include, but is not limited to, hand washing items provided as needed by site personnel.

Note: Site Reviewers are NOT expected to measure parking areas, pedestrian path of travel walkways and/or building structure on site. Points shall not be deducted if reasonable portion or reasonable alternative is made available on site. Specific measurements are provided strictly for "reference only" for the reviewer.

Section B	BH Office environment is maintained in a clean, safe and sanitary condition

8 CCR §5193; 28 CCR §1300.80

The physical appearance of floors/carpets, walls, furniture, patient areas and restrooms are clean and well maintained. Appropriate sanitary supplies, such as toilet tissue, hand washing soap, cloth/paper towels or antiseptic novelettes are made available for restroom use. Environmental safety includes the "housekeeping" or hygienic condition of the site. Clean means unsoiled, neat, tidy, and uncluttered. Well maintained means being in good repair or condition. Reception area is provided.

ACCESS/SAFETY

Section C | **BH Office environment is safe for all patients and personnel**

Ordinances: Site must meet city, county and state fire safety and prevention ordinance. Also, there is adequate patient and visitor parking provided.

Non-medical emergency procedures: Non-medical emergencies include incidents of fire, natural disaster (e.g. earthquakes), workplace violence, bomb threats, terrorism, de-escalation techniques, etc. Specific information for handling fire emergencies and evacuation procedures is available on site to staff. Personnel know where to locate information on site, and how to use information. Evidence of training must be verifiable, and may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc.

Evacuation Routes: Clearly marked, easy-to-follow escape routes are posted in visible areas, such as hallways, rooms and waiting areas. The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route, but may be reduced to a minimum of 32 inches at a doorway.

Illumination/Ventilation: Lighting is adequate in patient flow working and walking areas such as corridors, walkways, waiting, counseling rooms, and restrooms to allow for a safe path of travel. Along with adequate lighting, there is adequate ventilation provided in all areas.

Access Aisle: Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) provide a clear circulation path. Means of egress (escape routes) are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other emergency. Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. Cords (including taped cords) or other items are not placed on or across walkway areas.

*(Critical Elements) - Exits: Exit doorways are unobstructed and clearly marked by a readily visible "Exit" sign.

Electrical Safety: Electrical cords are in good working condition with no exposed wires, or frayed or cracked areas. Cords are not affixed to structures, placed in or across walkways, extended through walls, floors, and ceiling or under doors or floor coverings. Extension cords are not used as a substitute for permanent wiring. All electrical outlets have an intact wall faceplate. Sufficient clearance is maintained around lights and heating units to prevent combustible ignition.

Fire Fighting/Protection Equipment: There is firefighting/protection equipment in an accessible location on site at all times. An accessible location is reachable by personnel standing on the floor, or other permanent working area, without the need to locate/retrieve step stool, ladder or other assistive devises. At least one of the following types of fire safety equipment is on site:

1) Smoke Detector with intact, working batteries
2) Fire Alarm Device with code and reporting instructions posted conspicuously at phones and employee entrances
3) Automatic Sprinkler System with sufficient clearance (10-in.) between sprinkler heads and stored materials.
4) Fire Extinguisher in an accessible location that displays readiness indicators or has an attached current dated inspection tag.

Smoking: Smoking is prohibited in potentially hazardous areas and permitted in designated areas.

General Safety: Hazards that might lead to slipping, falling, electrical shock, burns, poisoning, or other traumas are eliminated.

Section D | **Emergency health care.**

Site Specific Emergency procedures: Behavioral Health Practitioner/staff are aware of what steps to take when a medical or behavioral health emergency should occur. It is important they know to call "911".

OFFICE MANAGEMENT

Section A | **Behavioral Health Practitioner Coverage.**

Office Hours/Postings: The Behavioral Health practitioner dates and hours of service are posted and/or provided to the member. Providers who lack malpractice insurance/coverage have posted such information in a prominent location in their office/s. **NOTE:** Credentialing policy - VHP-SCVMC Credentialing-Recredentialing/All practitioners must furnish evidence of professional liability insurance coverage in the minimum amounts requirred by the Plan (Malpractice Liability Coverage in amounts equal to a minimum of $1 million per occurence/$3 million aggregate).

Arrangements/schedule for after-hours, etc.: Member is made aware of how to contact BH practitioner during after-hours, weekends and holidays. There is a process in place for practitioner coverage when practitioner is on vacation.

Emergency Telephone Information: VHP Provider Manual – All Providers must have a phone message that communicates the following information to members during and after office hours: "If this is an emergency, please call 911."

Telephone Answering Service: VHP Provider Manual – All Providers must have a phone message that communicates the following information to members during and after office hours: "If this is an emergency, please call 911." Each practitioner's phone message must specify: hours of operations, services, location/directions, on-call coverage, and length of wait-time for a return call from practitioner.

Section B | **Behavioral Health care services are readily available.**

Appointment Access: The process established on site provides timely access to appointments for routine care and urgent care. An organized system must be clearly evident (in use) for scheduling appointments appropriately, notifying and reminding members of scheduled appointments, and following up of missed or canceled appointments. Missed and/or canceled appointments, and contact attempts must be documented in the patient's medical record.

Page 2

VHP Timely Access Requirement – Non-urgent care appointments with Psychiatrist and Non-Medical BH Practitioner is within 10 business days.
VHP Requirement – Waiting time in office to see practitioner is within 30 minutes from registration.

SAMPLE

Page 3

OFFICE MANAGEMENT

Section C	**There is 24-hour access to interpreter services for non/limited English proficient (LEP) members.**

Interpreter services for all members either through telephone language services or interpreters on site is made available at no cost to member. Interpreter services will be offered even if a member is accompanied by a family member or friend that could provide interpretation services.

NOTE: VHP's policy discourages the use of family members or friends as interpreters unless the member indicates their wish to use a family member or friend after being informed of the availability of language assistance services at no cost to the member. VHP also discourages using the use of minors to interpret for a member. If a member insists in using a family member, documentation is required in the medical record the member denial to use an interpreter.

VHP Language Line phone number at (408) 808-6150 and is available 24/7/365 days for interpreter services.

Section D	**Member grievance/complaint processes is in place.**

22 CCR §538585; §56260; 28 CCR §1300.67

Practitioner or office staffs are aware of grievance process. Complaint forms and/or information are readily available.

Note: A "grievance" is defined as any written or oral expression of dissatisfaction and shall include any complaint.

Section E	**Medical record confidentiality is maintained according to State, Federal and VHP guidelines.**

QM 4.0 Medical Record Standards and Requirements.

Privacy: Patients have the right to privacy for consultation and in reception areas. Practices are in place to safeguard patient privacy (white noise or sound barriers).

Confidentiality: Personnel follows a process for maintaining confidentiality of individual patient information. Individual patient conditions or information is not discussed in front of other patients or visitors, displayed or left unattended in reception and/or patient flow areas.

Electronic/Paper medical records: Electronic/Paper medical record-keeping system procedures have been established to ensure patient confidentiality, prevent unauthorized access, and maintain upkeep of the system. Electronic-security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to ensure that recorded input is unalterable, and file recovery procedures. Computer confidentiality protection may also include use of encryption, detailed user access controls, computer screens being protected to ensure staff can only view content, computers with PHI are locked when not attended or in use by staff, transaction logs, and blinded files.

Record release: Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released. The release terms, such as to whom records are released and for what purposes, should also be described.

Medical Record retention: Medical records must be maintained for ten (10) years following patient discharge. Hospital, acute psychiatric hospitals, skill nursing facilities, primary care clinics, psychology and psychiatric clinics must maintain medical records and exposed x-rays for a minimum of 10 years following patient discharge, except for minors (Title 22, CCR, Section 75055). Records for minors must be maintained for at least one year after a minor has reached age 18, but in no event for less than 7 years (Title 22, CCR, Section 75055). Destruction of medical records must be done in a manner that ensures that medical information cannot be retrieved in any form.

MEDICATIONS

Section A	**Medication secured to prevent unauthorized access.**

CA B&P Code §4051.3, §4071, §4172; 22 CCR §75037(a-g), §75039; 21 CFR §1301.75, §1301.76, §1302.22

Security: All drugs for dispensing are stored in an area that is secured at all times (CA B&P Code, §4051.3). Keys to locked storage area are available only to staff authorized by the physician to have access (16 CCR, Chapter 2, Division 3, Section 1356.32). The Medical Board of California interprets "all drugs" to also include both sample and over-the-counter medications. The Medical Board defines "area that is secure" to mean a locked storage area within a physician's office.

Storage: Medications are kept separate from food, cleaning supplies, and other items that may potentially cause contamination.

Expiration date: The manufacturer's expiration date must appear on the labeling of all medication. All prescription medication not bearing the expiration date are deemed to have expired. Expired medication may not be distributed or dispensed. There is a process in place to monitor for expired medications.

BEHAVIORAL HEALTH EDUCATION

Section A	**Health Education services are available to Plan members.**
	Health Education materials: Materials may be located in an accessible area on site (e.g., counseling room, waiting room) or provided to members by staff. There is information about crisis intervention available.

Reference Document: California Department of Services, Medi-Cal Managed Care Division

![Valley Health Plan logo] SAMPLE

Medical Clinic/Office

Audit Tool

Practitioner Name: **Review Date:**

Practitioner Address: **Reviewer Name/Title:**

Contact Person/Title:

No# of Staff on Site   /Physician   /NP   /CNM   /PA

Visit Purpose
□ Monitoring
□ Corrective Action Plan -Follow Up
□ Other

Site Score		
1. Access/Safety	22 /	22
2. Personnel	10 /	10
3. Office Management	19 /	19
4. Medications	14 /	14
5. Prevention Services	1 /	1
6. Infection Preventin & Control	19 /	19
Total	85 /	85
	100%	

Site-Specific Certification(s)	
□ AAAHC	□ JCAHO
□ FQMH	□ NCQA
□ None	□ Other

Provider type	
□ Family Practice	□ Internal Medicine
□ Pediatrics	□ OB-GYN
□ General Practitioner	

Performance Standard
□ **Pass**: 90% and met critical elements *
□ **Pass**: 90% did not meet a critical elements *
□ **Not Pass**: Below 89%
□ CAP Required
□ Other Follow-Up
*Critical element - these are identified with an asterisk and the number is bolded

Clinic/Office Type	
□ Primary Care	
□ Community Clinic	
□ Other	N/A Surgical Center

Scoring Procedure

1) Site score is total point only. The site score is one (1) or zero (0), there are not half points (0.5) given.

2) Add points given in each section

3) Add total points given in each sections.

4) Adjust score for "N/A" criteria (if needed). Subtract "N/A" points from _____total points possible.

5)Divide total points given by _____ or by "adjusted" total rate.

6) Multiply by 100 to get the performance score.

7) **Calculate**

_____ - _____ = x100 = _____

 Point   Time Adjusted   Performance
 Given   Point   Standard

Section		Access/Safety Audit Criteria	Yes	No	N/A	Audit Score	Score	Comment
A.		**Site is accessible and useable by individuals with physical disabilities.**						
A.	1	Clearly marked (blue) curb or sign designating disabled-parking space near assessable primary entrance.	x			1	1	
A.	2	Pedestrian ramps have a level landing at the top and bottom of the ramp.	x			1	1	
A.	3	Exit doorway openings allow for clear passage of a person in a wheelchair.	x			1	1	
A.	4	Accessible passenger elevator or reasonable alternative for multi-level floor accommodation.	x			1	1	
A.	5	Clear floor space for wheelchair in waiting area and exam room.	x			1	1	
A.	6	Wheelchair accessible restroom facilities or reasonable alternative.	x			1	1	
B.		**Site environment is maintained in a clean, safe, and sanitary condition.**						
B.	1	All patients areas including floor/carpet, walls, and furniture are neat, clean, well maintained and the space allocated for a particular function or service is adequate for the activities performed therein.	x			1	1	
B.	2	Restrooms are clean and contain appropriate sanitary supplies.	x			1	1	
B.	3	Reception areas are provided in accordance with visitor volume.	x			1	1	
C.		**Site environment is safe for all members, visitors and personnel.**						
C.	2	Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location.	x			1	1	
C.	3	Lighting is adequate in all areas to ensure safety.	x			1	1	
C.	4	Exit doors and aisles are unobstructed and egress (escape) accessible. The facility has stairwells protected by fire doors, if applicable.	x			1	1	
C.	5	***(Critical Element) - Exit doors are clearly marked with "Exit" signs.**	x			1	1	
C.	6	Electrical cords and outlets are in good working condition.	x			1	1	
C.	7	Fire fighting/protection equipment is accessible.	x			1	1	
D.		**Emergency health care services are available and accessible 24 hours a day, 7 days a week.**						
D.	1	Emergency medical equipment is stored together in easily accessible location.	x			1	1	
D.	2	Emergency phone number contacts are posted.	x			1	1	

Reference: California Department of Services, Medi-Cal Care Division
1

D.	3	*(Critical Element) -Airway management: oxygen delivery system (i.e. oxygen tank is charged and in good working order).	x			1	1	
D.	4	Document checking of emergency equipment/supplies for expiration and operating status at least monthly.	x			1	1	

Reference: California Department of Services, Medi-Cal Care Division

2

Section		Access/Safety Audit Criteria	Yes	No	N/A	Audit Score	Score	Comment
E.		**Medical and lab equipment's used for member care is properly maintained.**						
E.	1	Exam tables are in good repair.	x			1	1	
E.	2	Scales: function properly.	x			1	1	
E.	3	Medical equipment's is clean, functioning properly and maintained in operational condition.	x			1	1	
E.	4	Written documentation demonstrates the appropriates maintenance of all specialized medical equipment according to equipment manufacturer's guidelines.	x			1	1	
E.	5	Lab test supplies are not expired.	x			1	1	
		Total	24	0		22	22	

Section		Personnel Audit Criteria	Yes	No	N/A	Audit Score	Score	Comment
A		**Professional health care personnel have current California licenses and certifications.**						
A	1	All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current.	x			1	1	
B		**Personnel are qualified and trained for assigned responsibility.**						
B	1	Only qualified/trained personnel retrieve, prepare or administer medications.	x			1	1	
B	2	Only qualified/trained personnel operate medical equipment.	x			1	1	
B	3	Documentation of education/training for non-licensed medical personnel is maintained on site.	x			1	1	
C		**Personnel receive training/information.**						
C	1	Infection prevention and control – universal/standard precautions.	x			1	1	
C	2	Patient confidentiality.	x			1	1	
C	3	Abuse reporting.	x			1	1	
C	4	Member's rights.	x			1	1	
C.	1	Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.	x			1	1	

Reference: California Department of Services, Medi-Cal Care Division

3

C.	5	Emergency non-medical procedures (e.g. site evacuation, workplace violence).	x			1	1	
		Total	10	0		10	10	

Reference: California Department of Services, Medi-Cal Care Division   4

Section		Office Management Audit Criteria	Yes	No	N/A	Audit Score	Score	Comment
A.		**Practitioner coverage is available 24 hours a day, 7 days a week.**						
A.	1	Medical Office/Clinic office hours are posted, or readily available upon request. Provider/s who lack malpractice insurance coverage post the information.	x			1	1	
A.	2	Arrangement/schedule for after-hours, on-call, supervisory back-up physician coverage is available to site staff.	x			1	1	
A.	3	Emergency telephone instructions are made available to members.	x			1	1	
A.	4	Telephone answering machine, voice mail system or answering service is used whenever office staff does not directly answer phone calls and periodically updated.	x			1	1	
B.		**Health care services are readily available.**						
B.	1	Appointments are scheduled according to patients' stated clinical needs within the timeliness standards established.	x			1	1	
B.	2	Patients are notified of scheduled routine and/or preventive screening appointments.	x			1	1	
B.	3	There is a system in place to follow-up on missed and canceled appointments.	x			1	1	
B.	4	Primary Care Practitioner and/or scheduling staff are aware an appointment is to be available within ten (10) business days.	x			1	1	
B.	5	Primary Care Practitioner and/or staff are aware member wait time in office from registration to seeing Primary Care practitioner is within thirty (30) minutes.	x			1	1	
C.		**There is 24-hour access to interpreter services for limited-English proficient members.**						
C.	1	Interpreter services are made available.	x			1	1	
D.		**Member Grievance/Complaint processes is established on site.**						
D.	1	Phone number(s) for filing grievances/complaints are located on site.	x			1	1	
D.	2	Complaint forms and/or copy of the grievance process are available on site.	x			1	1	
D.	3	Member's right to change primary care physician is located on site.	x			1	1	
E.		**Medical records are available for the Provider at each scheduled member encounter.**						
E.	1	Medical records are readily retrievable for scheduled member encounters.	x			1	1	
F.		**Confidentiality of personal medical information is protected according to State and Federal guidelines**						
F.	1	Exam rooms and dressing areas safeguard patients' right to privacy.	x			1	1	
F.	2	Procedures are followed to maintain the confidentiality of personal patient information with medical record whether paper or electronic.	x			1	1	
F.	3	Medical record release procedures are compliant with State and Federal guidelines.	x			1	1	

Reference: California Department of Services, Medi-Cal Care Division   5

F.	4	Storage, transmittal and destruction of medical records preserves confidentiality and security.	x			1	1	
F.	5	Medical records are retained for 10 years.	x			1	1	
		Total	19	0		19	19	

Reference: California Department of Services, Medi-Cal Care Division

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Section		Medications Audit Criteria	Yes	No	N/A	Audit Score	Score	Comment
A.		**Medication and medication supplies are maintained secure to prevent unauthorized access.**						
A.	1	Medication are stored in specifically designated cupboards, cabinets, closets or drawers.	x			1	1	
A.	2	Prescription, sample and over-the counter medication, hypodermic needles/syringes, prescription pads are securely stored in a lockable space (cabinet or room) within the office/clinic.	x			1	1	
A.	3	Controlled medication are stored in a locked space accessible only to authorized personnel.	x			1	1	
A.	4	A dose-by-dose controlled substance distribution log is maintained.	x			1	1	
B.		**Medication are handled safely and appropriately stored.**						
B.	1	Medication are prepared in a clean area, or "designated clean" area if prepared in a multipurpose room.	x			1	1	
B.	2	Items other than medications in refrigerator/freezer are kept in a secured, separate compartment from medication.	x			1	1	
B.	3	Refrigerator thermometer temperature is 35º-46º Fahrenheit or 2º-8º Centigrade (at time of site visit).	x			1	1	
B.	4	Freezer thermometer temperature is 5º Fahrenheit or –15º Centigrade, or lower (at time of site visit).	x			1	1	
B.	5	Daily temperature readings of medication refrigerator and freezer are documented.	x			1	1	
B.	6	Hazardous substances are appropriately labeled.	x			1	1	
B.	7	Site has method(s) in place for drug and hazardous substance disposal.	x			1	1	
C.		**Medications are dispensed according to State and Federal drug distribution laws and regulations.**						
C.	1	There are no expired medication on site.	x			1	1	
C.	2	Site has a procedure to check expiration date of all medications (including vaccines and samples).	x			1	1	
C.	3	Medications are all stored and dispensed prescription medication are appropriately labeled.	x			1	1	
		Total	14	0		14	14	

Section	Health Education Audit Criteria	Yes	No	N/A	Audit Score	Score	Comment
A.	**Health education materials are available.**						

Reference: California Department of Services, Medi-Cal Care Division

7

A.	1	Readily accessible on site, or are made available upon request.	x			1	1	
B.		**Facility Tool *Pilot Question**						
B.	1	There is a procedure in place, to alert the practitioner their patient is in need of preventive screening (ex. Mammogram, pap smear).	x			N/A	0	
		Total	1	2		1	1	

Reference: California Department of Services, Medi-Cal Care Division   8

Section		Infection Prevention and Control Audit Criteria	Yes	No	N/A	Audit Score	Score	Comment
A.		**Infection control procedures for Standard/Universal precautions are followed.**						
A.	1	Antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.	x			1	1	
A.	2	A waste disposal container is available in exam rooms, procedure/treatment rooms and restrooms.	x			1	1	
A.	3	Site has procedure for effectively isolating infectious members with potential communicable conditions.	x			1	1	
B.		**Site is compliant with OSHA Blood Borne Pathogens Standard and Waste Management Act**						
B.	1	Personal Protective Equipment is readily available for staff use.	x			1	1	
B.	2	Needle stick safety precautions are practiced on site.	x			1	1	
B.	3	Blood, other potentially infectious materials and regulated wastes are placed in appropriate leak-proof, labeled containers for collection, handling, processing, storage, transport or shipping.	x			1	1	
B.	4	Biohazardous (non-sharp) wastes are contained separate from other trash/waste.	x			1	1	
B.	5	Contaminated linen is laundered at the workplace or at a commercial laundry or disposable equipment used.	x			1	1	
C.		**Contaminated surfaces are decontaminated according to Cal-OSHA Standards**						
C.	1	Equipment and work surfaces are appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.	x			1	1	
C.	2	Routine cleaning and decontamination of equipment/work surfaces is completed according to site-specific written schedule.	x			1	1	
C.	3	Disinfectant solutions used on site are: approved by the Environmental Protection Agency (EPA), effective in killing HIV/HBV/TB, and used according to manufacturer recommendation.	x			1	1	
D.		**Reusable medical instruments are properly sterilized after each use.**						
D.	1	Written site-specific procedures or Manufacturer's Instructions for instrument/equipment cleaning and sterilization are available to staff.	x			1	1	
		Staff adheres to site-specific procedures and/or manufacturer/product label directions for the following procedures:	x			1	1	
D.	2	Cleaning reusable instruments/equipment prior to sterilization.	x			1	1	
D.	3	Cold chemical sterilization.	x			1	1	
D.	4	Autoclave/steam sterilization.	x			1	1	
D.	5	Autoclave maintenance	x			1	1	

Reference: California Department of Services, Medi-Cal Care Division   9

D.	6	Spore testing of autoclave/steam sterilizer with documented results (at least monthly).	x			1	1	
D.	7	Sterilized packages are labeled with sterilization date and loaded identification information.	x			1	1	
		Total	19	0		19	19	

Reference: California Department of Services, Medi-Cal Care Division   10

Purpose: Medical Office/Clinic Review Guidelines provide the standards, directions, instructions, rules, regulations, perimeters, or indicators for the clinic/office site review audit. These guidelines shall be used for assessing, measuring, evaluating, and making decisions.

Scoring: The audit includes on-site observation and discussion with personnel. Reviewers use reasonable evidence available during the review process to determine if practices and systems on site meet audit criteria. Pass: 90% or above or Not Pass: below 90%. A corrective action plan will be required even if the pass score is achieved when a critical element was not met. Performance scores are based on **86** total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Score full point(s) if survey item is met. Score zero (0) points if item is not met. Do not score partial points for any criteria. Explain all "N/A" and "No" (0 point) items in the comment section.

ACCESS/SAFETY

Section A	**Medical Office/Clinic is accessible and useable by individuals with physical disabilities.**

3 CCR §504; 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III)

ADA Regulations: Site must meet city, county and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. All facilities designed, constructed; or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992 (28 CFR 35.151). Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs (28 CFR 36.402).

Parking: Parking spaces for persons with physical disabilities are located in close proximity to handicap-accessible building entrances. Each parking space reserved for the disabled is identified by a permanently affixed reflectorized sign posted in a conspicuous place. If provider has no control over availability of disabled parking lot or nearby street spaces, provider must have a plan in place for making program services available to persons with physical disabilities.

Ramps: A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. Any path of travel is considered a ramp if its slope is greater than a 1-foot rise in 20 feet of horizontal run.

Exit doors: The width of exit doorways (at least 32-in.) allows for passage clearance of a wheelchair. Exit doors include all doors required for access, circulation and use of the building and facilities, such as primary entrances and passageway doors. Furniture and other items do not obstruct exit doorways or interfere with door swing pathway.

Elevators: If there is no passenger elevator, a freight elevator may be used to achieve program accessibility if it is upgraded for general passenger use and if passageways leading to and from the elevator are well-lit, neat and clean.

Clear Floor Space: Clear space in waiting/exam areas is sufficient (at least 30-in. x 48-in.) to accommodate a single, stationary adult wheelchair and occupant. A minimum clear space of 60-in. diameter or square area is needed to turn a wheelchair.

Restrooms: Restroom and hand washing facilities are accessible to able-bodied and physically disabled persons. A wheelchair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close. The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route, but may be reduced to a minimum of 32 inches at a doorway. If wheelchair accessible restrooms are not available within the office site, reasonable alternative accommodations are provided which may include a wheelchair accessible restroom located in a nearby office or shared within a building. Sufficient knee clearance space underneath the sink allows for wheelchair users to safely use a lavatory sink for hand washing. A reasonable alternative may include, but is not limited to, hand washing items provided as needed by site personnel.

Note: Site Reviewers are NOT expected to measure parking areas, pedestrian path of travel walkways and/or building structure on site. Points shall not be deducted if reasonable portion or reasonable alternative is made available on site. Specific measurements are provided strictly for "reference only" for the reviewer.

Section B	**Medical Office/Clinic environment is maintained in a clean, safe and sanitary condition**

8 CCR §5193; 28 CFR §1300.80

The physical appearance of floors/carpets, walls, furniture, patient areas and restrooms are clean and well maintained. Appropriate sanitary supplies, such as toilet tissue, hand washing soap, cloth/paper towels or antiseptic novelettes are made available for restroom use. Environmental safety includes the "housekeeping" or hygienic condition of the site. Clean means unsoiled, neat, tidy, and uncluttered. Well maintained means being in good repair or condition. Reception areas are provided in accordance with visitor volume.

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ACCESS/SAFETY	
Section C	**Site environment is safe for all patients, visitors and personnel**

Ordinances: Site must meet city, county and state fire safety and prevention ordnances. Also, there is adequate patient and visitor parking provided.

Evacuation Routes: Clearly marked, easy-to-follow escape routes are posted in visible areas, such as hallways, exam rooms and patient waiting areas. The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route, but may be reduced to a minimum of 32 inches at a doorway.

Illumination/Ventilation: Lighting is adequate in patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel. Along with adequate lighting, there is adequate ventilation provided in all areas.

Access Aisle: Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, staircases, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) provide a clear circulation path. Means of egress (escape routes) are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other emergency. Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. Cords (including taped cords) or other items are not placed on or across walkway areas.

*Exits: Exit doorways are unobstructed and clearly marked by a readily visible "Exit" sign.

Electrical Safety: Electrical cords are in good working condition with no exposed wires, or frayed or cracked areas. Cords are not affixed to structures, placed in or across walkways, extended through walls, floors, and ceiling or under doors or floor coverings. Extension cords are not used as a substitute for permanent wiring. All electrical outlets have an intact wall faceplate. Sufficient clearance is maintained around lights and heating units to prevent combustible ignition.

Fire Fighting/Protection Equipment: There is firefighting/protection equipment in an accessible location on site at all times. An accessible location is reachable by personnel standing on the floor, or other permanent working area, without the need to locate/retrieve step stool, ladder or other assistive devises. At least one of the following types of fire safety equipment is on site:
1) Smoke Detector with intact, working batteries
2) Fire Alarm Device with code and reporting instructions posted conspicuously at phones and employee entrances
3) Automatic Sprinkler System with sufficient clearance (10-in.) between sprinkler heads and stored materials.
4) Fire Extinguisher in an accessible location that displays readiness indicators or has an attached current dated inspection tag.

Smoking: Smoking is prohibited in potentially hazardous areas and permitted in designated areas.
General Safety: Hazards that might lead to slipping, falling, electrical shock, burns, poisoning, or other traumas are eliminated.

Section D	**Emergency health care services are available and accessible 24 hours a day, 7 days a week**

Emergency medical equipment and phone numbers: During business hours providers are prepared to provide emergency services for management of emergency medical conditions that occur on site until the emergent situation is stabilized and/or treatment is initiated by the local 911 Emergency Medical Service (EMS) system. Emergency phone numbers are posted. Minimum emergency equipment is available on site to:
1) Establish and maintain a patent/open airway, and
2) Manage anaphylactic reaction.

Emergency equipment, supplies and medication, appropriate to patient population, are available in an accessible location. An accessible location is one that is reachable by personnel standing on the floor, or other permanent working area, without locating/retrieving step stool, ladder or other assistive devices. For emergency "Crash" cart/kit, contents are appropriately sealed and are within the expiration dates posted on label/seal. Site personnel are appropriately trained and can demonstrate knowledge and correct use of all medical equipment they are expected to operate within their scope of work. **Documented evidence that emergency equipment is checked at least monthly may include a log, checklist or other appropriate method(s).**

*Airway management: Minimum airway control equipment includes a wall oxygen delivery system or portable oxygen tank with masks and tubing. Portable oxygen tanks are maintained at least ¾ full (charged). There is a method/system in place for oxygen tank replacement.

Medical Office/Clinic Specific Emergency procedures: Staff have been trained are able to describe site-specific actions or procedures for handling medical emergencies until the individual is stable or under care of local emergency medical services (EMS). It is important they know to call "911. Emergency phone numbers are posted.

Section E	**Medical and lab equipment used for patient care is properly maintained**

Examination table: A protective barrier that is changed between patient contact is used to cover exam table surface. "Good repair" means clean and well maintained in proper working order.

Scales: Scales are clean and working properly.

Medical and laboratory equipment and supplies: All equipment and supplies used to measure or assess patient health status/condition is functioning properly and none have expired date. All specialized equipment (e.g., ultrasonography equipment, electrocardiogram (EKG) machine, defibrillator, audiometer, hemoglobin meter, glucometer, scales, etc.) **is adequately maintained according to the specified manufacturer's guidelines for the equipment, and/or is serviced annually by a qualified technician.**
Documentation: There is documented evidence that standard operating procedures have been followed for routine inspection.

PERSONNEL		

Section A Professional health care personnel have current California licenses and certifications

Medical Professional	License/Certification	Issuing Agency
Certified Nurse Midwife (CNM)	RN License and Nurse Midwife Certificate	CA Board of Registered Nursing
Doctor of Osteopathy (DO)	Physician's Certificate DEA Registration	Osteopathic Medical Board of CA Drug Enforcement Administration
Licensed Vocational Nurse (LVN)	LVN License	CA Board of Vocational Nursing and Psychiatric Technicians
Nurse Practitioner (NP)	RN License w/NP Certification and Furnishing Number	CA Board of Registered Nursing
Physician (MD)	Physician's Certificate DEA Registration	Medical Board of CA Drug Enforcement Administration
Physicians' Assistant (PA)	PA License	Physician Assistant Examining Committee/Medical Board of CA
Registered Dietitian (RD)	Registration Card	Commission on Dietetic Registration
Registered Nurse (RN)	RN License	CA Board of Registered Nursing

Note: All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California. Any license/certifications that has been approved during the re-credentialing process need not be re-checked during the site review. Any licenses/certifications not included in the re/credentialing process must be checked for current status as part of the site review process. Although sites with centralized personnel departments are not required to keep documents or copies on site, copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers.

Section B Medical Office/Clinic personnel are qualified and trained for assigned responsibilities.

Medical equipment: Provider and/or staff are able to demonstrate appropriate operation of medical equipment used in their scope of work. Not all staff is required to be proficient in use of all equipment.

Non-licensed personnel: Medical assistants (MA) are unlicensed health personnel, at least 18 years of age, who perform basic administrative, clerical, and non-invasive routine technical supportive services under the supervision of a licensed physician, in a medical office or clinic setting. Supervision means the licensed physician must be physically present in the treatment facility during the performance of authorized procedures by the MA. Training may be administered under a licensed physician; or under a RN, LVN, PA, or other qualified medical assistant acting under the direction of a licensed physician. The supervising physician is responsible for determining the training content and ascertaining proficiency of the MA. Training documentation maintained on site for the MA must include the following:

A)   Diploma or certification from an accredited training program/school, or

B)   Letter/statement from the current supervising physician that certifies in writing: date, location, content, and duration of training, demonstrated proficiency to perform current assigned scope of work, and signature.

Medications: Unlicensed staff (e.g. medical assistants) has evidence of appropriate training and supervision in all medication administration methods performed within their scope of work. Medication administration by a MA means the direct application of pre-measured medication orally, sublingually, topically, vaginally or rectally; or by providing a single dose to a patient for immediate self-administration by inhalation or by simple injection. The pre-labeled medication container must be shown to the licensed person prior to administration. To administer medications by subcutaneous or intramuscular injection, or to perform intradermal skin tests or venipuncture for withdrawing blood, an MA must have completed at least the minimum number of training-hours established in CCR, Title 16, Section 1366.1. An MA may administer injections of scheduled drugs, including narcotic medications, only if the dosage is verified and the injection is intradermal, subcutaneous, or intramuscular. Medical assistants may not place an intravenous needle, start or disconnect the intravenous infusion tube, administer medications or injections into an intravenous line, or administer anesthesia. The supervising physician must specifically authorize all medications administered by an MA. Authorization means a specific written or standing order prepared by the supervising physician.

CPR/Basic CPR: Licensed staff have a current CPR certificate.

Note: Personnel on site must be qualified for their responsibilities and adequately trained for their scope of work. Site staff should have a general understanding of the systems/processes in place, appropriate supervision and knowledge of the available sources of information on site.

PERSONNEL	
Section C	**Medical/Clinic personnel receive safety and member right's training/information.**

Infection Control: Site personnel receiving training about bloodborne pathogens.
Training on universal/standard precautions which includes personal protective equipment and handling of bio hazardous waste(s).
Personnel must know where to locate information/resources on site about infection control, the Blood borne Pathogens Exposure Plan, and how to use the information. Evidence of training may include informal in-services, new staff orientation, external training courses, educational curriculum and participation lists, etc. Training documentation must contain the employee's name, job titles, training date(s), type of training, contents of training session, and names/qualifications of trainers. Records must be kept for three (3) years.

Abuse Reporting: Site personnel have specific knowledge of local reporting requirements, agencies, and procedures, and know where to locate information on site and how to use information.
Note: Health practitioners (e.g., physicians, surgeons, licensed nurses, licensed social workers, paramedics) in a health facility, (e.g., clinic, physician's office, public health clinic) are legally mandated reporters of known or reasonably suspected cases of child abuse, elder abuse and domestic violence. Legally mandated reporters must make telephone and written reports according to timeliness standards established by the designated local law enforcement agencies in each county. "Reasonably suspects" means having objectively reasonable suspicion based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect abuse (CA Penal Code 11164). Failure to report by legally mandated reporters can result in criminal or civil prosecutions, punishable by monetary fines and/or county jail confinement. Any person entering employment which makes him/her a mandated reporter must sign a statement, provided and retained by the employer, that the employee has knowledge of the Child Abuse reporting law and will comply with its provision (CA Penal Code 11166.5).

Member's Rights: Clinic/Medical Office personnel have received information and/or training about member rights. Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. If there is no verifiable evidence of staff training, staff is able to locate written member rights information on site and explain how to use information.
Patient Confidentiality: Clinic/Medical Office personnel have received information and/or training about maintain confidentiality. Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc.
Non-medical emergency procedures: Non-medical emergencies include incidents of fire, natural disaster (e.g. earthquakes), workplace violence, bomb threats, terrorism, etc. Specific information for handling fire emergencies and evacuation procedures is available on site to staff. Personnel know where to locate information on site, and how to use
Medical Office/Clinic Specific Emergency procedures: Staff have been trained are able to describe site-specific actions or procedures for handling medical emergencies until the individual is stable or under care of local emergency medical services (EMS). It is important they know to call "911.

OFFICE MANAGEMENT	
Section A	**Physician coverage is available 24 hours a day, 7 days a week.**

Current clinic office hours are posted within the office or readily available upon request. When a physician is not on site during regular office hours, personnel are able to contact the physician (or covering physician) at all times by telephone, cell phone, pager, etc. Provider/s who lack malpractice insurance coverage have posted such information in a prominent location in their office/s. NOTE: Credentialing policy - VHP-SCVMC Credentialing-Recredentialing/All practitioners must furnish evidence of professional liability insurance coverage in the minimum amounts requirred by the Plan (Malpractice Liability Coverage in amounts equal to a minimum of $1 million per occurence/$3 million aggregate).

In addition to the physician, only appropriately licensed medical personnel such as a CNM, NP, RN, or PA handles emergency, urgent, and medical advice/triage telephone calls.

VHP Provider Manual – All Providers must have a phone message that communicates the following information to members during and after clinic hours: "If this is an emergency, please call 911."
Each provider's phone message must specify: Clinic hours of operations, clinic services, clinic location/directions, on-call coverage, and length of wait time for a return call from provider.

Section B	**Health care services shall be readily available.**

The process established on site provides timely access to appointments for routine care, urgent care, prenatal care, pediatric periodic health assessments/immunizations, adult initial health assessments and urgent care. An organized system must be clearly evident (in use) for scheduling appointments appropriately, notifying and reminding members of scheduled appointments, and following up of missed or canceled appointments. **Missed and/or canceled appointments, and contact attempts must be documented in the patient's medical record.**

DMHC Time Access Regulation – Non-urgent care appointments with Primary Care Physician is within 10 business days.

VHP Requirement – Waiting time in office (definition: within 30 minutes from registration/appointment time to seeing primary care physician)

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	OFFICE MANAGEMENT
Section C	**There is 24-hour access to interpreter services for non/limited English proficient (LEP) members.**
	All sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site. Interpreter services will be offered even if a member is accompanied by a family member or friend that could provide interpretation services.
	VHP's policy discourages the use of family members or friends as interpreters unless the member indicates as their wishes to use a family member or friend after being informed of the availability of language assistance services at no cost to the member. VHP also discourages using the use of minors to interpret for a member. If a member insists in using a family member, documentation is required in the medical record the member denial to use an interpreter.
	Clinic/Medical Offices can call the VHP Language Line phone number at (408) 808-6150 which is available 24/7/365 days for interpreter services.
Section D	**Member grievance/complaint processes is in place.**
	22 CCR §538585; §56260; 28 CCR §1300.67
	At least one telephone number for filing grievances is posted on site, or is readily available upon request. Complaint forms and a copy of the grievance procedure are readily available on site, and can be provided to members upon request. Information is publicly posted that a member has a right to change primary care physician.
	Note: A "grievance" is defined as any written or oral expression of dissatisfaction and shall include any complaint.
Section E	**Medical records are available for the Provider at each scheduled patient encounter.**
	22 CCR §75055; 28 CCR §1300.80
	The process/system established on site provides for the availability of medical records, including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters. Medical records are filed that allows for ease of accessibility within the facility, or in an approved health record storage facility off the facility premises (22 CCR, § 75055).
Section F	**Medical record confidentiality is maintained according to State, Federal and VHP guidelines.**
	QM 4.0 Medical Record Standards and Requirements
	Privacy: Patients have the right to privacy for dressing/undressing, physical examination, medical consultation and in reception areas. Practices are in place to safeguard patient privacy. Because dressing areas and examination room configurations vary greatly, reviewers will make site-specific determinations.
	Confidentiality: Personnel follow site process for maintaining confidentiality of individual patient information. Individual patient conditions or information is not discussed in front of other patients or visitors, displayed or left unattended in reception and/or patient flow areas.
	Electronic/Paper Medical records: Electronic/Paper medical record-keeping system procedures have been established to ensure patient confidentiality, prevent unauthorized access, and maintain upkeep of the system. Electronic-security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to ensure that recorded input is unalterable, and file recovery procedures. Computer confidentiality protection may also include use of encryption, detailed user access controls, computer screens being protected to ensure staff can only view content, computers with PHI are locked when not attended or in use by staff, transaction logs, and blinded files.
	Medical record release: Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released. The release terms, such as to whom records are released and for what purposes, should also be described.
	Record retention: Medical records must maintain medical records of 10 (ten years) following patient discharge. Destruction of medical records must be done in a manner that ensures that medical information cannot be retrieved in any form.
	MEDICATIONS
Section A	**Medication and medication supplies are maintained secured to prevent unauthorized access.**
	CA B&P Code §4051.3, §4071, §4172; 22 CCR §75037(a-g), §75039; 21 CFR §1301.75, §1301.76, §1302.22
	Controlled substances: Written records are maintained of controlled substances inventory list(s) that includes: provider's DEA number, name of medication, original quantity of medication, dose, date, name of member receiving medication, name of authorized person dispensing medication, and number of remaining doses. Controlled substances are stored separately from other medications in a securely locked, substantially constructed cabinet (Control Substances Act, CFR 1301.75). Control substances include all Schedule I, II, III, IV, and V substances listed in the CA Health and Safety Code, Sections 11053-11058, and do not need to be double locked. Personnel with authorized access to controlled substances include physicians, physician's assistants, licensed nurses and pharmacists.
	Security: All drugs for dispensing are stored in an area that is secured at all times (CA B&P Code, §4051.3). Keys to locked storage area are available only to staff authorized by the physician to have access (16 CCR, Chapter 2, Division 3, Section 1356.32). The Medical Board of California interprets "all drugs" to also include both sample and over-the-counter medications. The Medical Board defines "area that is secure" to mean a locked storage area within a physician's office.
	Note: During business hours, the drawer, cabinet or room containing drugs, medication supplies or hazardous substances may remain unlocked only if there is no access to area by unauthorized persons. Whenever drugs, medication supplies or hazardous substances are unlocked, authorized clinic personnel must remain in the immediate area at all times. At all other times, drugs, medication supplies and hazardous substances must be securely locked. Controlled substances are locked at all times.

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MEDICATIONS	
Section B	**Medications are handled safely and appropriately stored.**
	Medication preparation: A medication or device is considered "adulterated" if it contains any filthy, putrid, or decomposed substance, or if it has been prepared, packed or held under unsanitary conditions (21 USC, Section 351). A medication is considered contaminated if it has been held under unsanitary conditions that may have been contaminated with filth, or rendered injurious to health.
	Storage: Drugs are stored under appropriate conditions of temperature, humidity, and light so that the identity, strength, quality, and purity of the drug product is not affected (21 CFR, Section 211.142). Room temperature where medications are stored does not exceed 30ºC (86ºF) (Title 22, Section 75037 (d)). Medications are not stored with food, lab specimens, etc.
	Immunobiologics: Vaccines are refrigerated immediately upon receipt on site and stored according to specific instructions on the package insert for each vaccine. Vaccines, such as MMR, DTP, DTaP, DT, Td, Hep A, Hep B, Enhanced Inactivated Polio (E-IPV), and Pneumococcal, are kept in a refrigerator maintained at 2º to 8ºC or 35º to 46ºF. MMR and varicella are protected from light at all times, and kept cold. Vaccines are not stored in the doors of refrigerator or freezer. Diluent does not need refrigeration if vaccine is administered right after diluent is added. Oral polio vaccine (OPV) and varicella vaccines are stored in the freezer at -15ºC or 5ºF, or lower. If stored vaccines are in solid state and contain ice crystals on the outside of vial, vaccines are considered appropriately frozen. Refrigerator and freezer temperatures is checked at least once each day and findings documented.
	Hazardous substances labeling: Safety practices are followed in accordance with current/updated CAL-OSHA standards. The manufacturer's label is not removed from a container (bag, bottle, box, can, cylinder, etc.) as long as the hazardous material or residues of the material remain in the container. All portable containers of hazardous chemicals and secondary containers into which hazardous substances are transferred or prepared require labeling. Labels must provide the following information: identity of hazardous substance, description of hazard warning: can be words, pictures, and symbols date of preparation or transfer.
	Note: The purpose of hazard communication is to convey information about hazardous substances used in the work place. A hazardous substance is any substance that is a physical or health hazard. Examples of a physical hazard include substances that are a combustible liquid, a compressed gas, explosive, flammable, an organic peroxide, an oxidizer, pyrophoric, unstable (reactive) or water-reactive. Examples of a health hazard include substances where acute or chronic health effects may occur with exposure, such as carcinogens, toxic or highly toxic agents, irritants, corrosives, sensitizers and agents that damage the lungs, skin, eyes, or mucous membranes. **Drug disposal information can be found on the Santa Clara County Recycle and Waste Reduction Division website.**
Section C	**Medications are dispensed according to State and Federal drug distribution laws and regulations.**
	Expiration date: The manufacturer's expiration date must appear on the labeling of all medications. All prescription drugs not bearing the expiration date are deemed to have expired. If a drug is to be reconstituted at the time of dispensing, its labeling must contain expiration information for both the reconstituted and unconstituted medication. Expired medication may not be distributed or dispensed.
	Prescription labeling: Each prescription medication dispensed is in a container that is not cracked, soiled or without secure closures (Title 22, CCR, Section 75037 (a)). Medication container is labeled with the provider's name, patient's name, drug name, dose, frequency, route, quantity dispensed, and manufacturer's name and lot number. California Pharmacy Law does not prohibit furnishing a limited quantity of sample drugs if dispensed to the patient in the package provided by the manufacturer, no charge is made to the patient, and appropriate documentation is made in the patient's medical record (CA Business and Professions Code, Sections 4170, 4171).
	Drug dispensing: Medication dispensing is in compliance with all applicable State and federal laws and regulations.
medical EDUCATION	
Section A	**Health education materials.**
	Health Education materials: Materials may be located in an accessible area on site (e.g., exam room, waiting room, or health education room), or provided to members by clinic staff. Materials are provided in the members' language.

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INFECTION PREVENTION AND CONTROL	
Section A	**Infection control procedures for Standard/Universal precautions are followed.**

Hand washing facilities: Hand washing facilities are available in the exam room and/or utility room, and include an adequate supply of running potable water, soap and single use towels or hot air drying machines. Sinks with a standard faucet, foot-operated pedals, 4-6-inch wing-type handle, automatic shut-off systems or other types of water flow control mechanism are acceptable. On occasions when running water is not readily available, an antiseptic hand cleanser, alcohol-based hand rub, or antiseptic novelettes is acceptable until running water is available.

Antiseptic hand cleaner: Hand washing prevents infection transmission by removing dirt, organic material and transient microorganisms from hands. Hand washing with plain (non-antimicrobial) soap in any form (e.g., bar, leaflet, liquid, powder, granular) is acceptable for general patient care (Association for Professionals in Infection Control and Epidemiology, Inc., 1995). Antimicrobial agents or alcohol-based antiseptic hand rubs are used for hand washing when indicated to remove debris and destroy transient microorganisms (e.g., before performing invasive procedures, after contact with potentially infectious materials). Plain and antiseptic hand wash products are properly maintained and/or dispensed to prevent contamination.

Waste disposal container: Contaminated wastes (e.g. band aids, sanitary napkins, soiled disposal diapers) are disposed of in regular solid waste (trash) containers, and are maintained to prevent potential contamination of patient/staff areas and/or unsafe access by infants/children. Closed containers are not required for regular, solid waste trash containers.

Isolation procedures: Personnel are able verbally explain procedure(s) used on site to isolate patients with potentially contagious conditions from other patients. If personnel are unable to demonstrate or explain site-specific isolation procedures and cannot locate written isolation procedure instructions, site is considered deficient.

Note: Infection Control standards are practiced on site to minimize risk of disease transmission. Site personnel are expected to apply the principles of "Standard Precautions" (CDC, 1996), used for all patients regardless of infection status. Standard precautions apply to blood, all body fluids, non-intact skin, and mucous membranes, which are treated as potentially infectious for HIV, HBV or HCV, and other blood borne pathogens. "Universal precautions" refer to the OSHA mandated program that requires implementation of work practice controls, engineering controls, blood borne pathogen orientation/education, and record keeping in healthcare facilities.

Section B	**Medical Office/Clinic is compliant with OSHA Blood borne Pathogens and Waste Management Act (post-exposure reporting as required by County/State/Federal requirement).**

Personal Protective Equipment (PPE): PPE is available for staff use on site, and includes water repelling gloves, clothing barrier (e.g., gown, sheets), face/eye protection (e.g., goggles, face shield), and respiratory infection protection (e.g., mask). Availability of other necessary PPE is specific to the practice and types of procedures performed on site. PPE is specialized clothing and/or equipment for protection against blood borne pathogen hazards, and does not include general work clothes (e.g., uniforms, cloth lab coats) that permit liquid to soak through. General work clothes are appropriate only if blood/OPIM does not penetrate through employee's work clothes, undergarments, skin, eyes, mouth, or other mucous membranes under NORMAL conditions of use.

Blood and Other Potentially Infectious Materials (OPIM): OPIM are all human body fluids, any unfixed tissue or organ (other than intact skin) from a human (living or dead), and HIV or HBV-containing blood, cells, tissue, organs, cultures, medium or solutions. Containers for blood and OPIM are closable, leak proof, and labeled and/or color-coded. Double bagging is required only if leakage is possible.

Labels: A warning label is affixed to red bagged regulated wastes, sharps containers, refrigerators/freezers containing blood or OPIM, containers used to store or transport blood or OPIM, and contaminated laundry or equipment for storage or transporting. The international "BIOHAZARDOUS WASTE" label, (fluorescent orange or red-orange with contrasting lettering/symbols) is an integral part of the container or affixed to container. Sharps containers are labeled with the words "Sharps Waste" or with the international biohazard symbol and the word "BIOHAZARD". Individual containers of blood or OPIM are exempted from warning labels if placed inside a labeled secondary container for storage, transport, or disposal. Alternative marking or color coding may be used to label contaminated laundry or specimen containers if the alternative marking permits employees on site to recognize that container requires compliance with Universal Precautions. If the contaminated laundry or specimen leaves the site, an international "Bio hazardous Waste" warning label and/or red color-coding is required

Needle stick Safety: Contaminated sharps are discarded immediately. Sharps containers are located close to the immediate area where sharps are used, and are inaccessible to unauthorized persons. Sharps are not bent, removed from a syringe, or recapped except by using a one-handed technique. Needleless systems, needle devices and non-needle sharps are used unless exemptions have been approved by Cal/OSHA (8CCR, Section 5193). Security of portable containers in patient care areas is maintained at all times. Any device capable of cutting or piercing (e.g. syringes, hypodermic needles, needleless devices, blades, broken glass, slides, vials) are placed in a closable, puncture-resistant, labeled, leak-proof container. If these requirements are met, containers made of various materials (e.g., cardboard, plastic) are acceptable. Containers are not overfilled past manufacturer's designated fill line, or more than ¾ full. Supply of containers on hand is adequate to ensure routine change-out when filled.

Contaminated Linen: Contaminated linen (soiled with blood/OPIM or containing contaminated sharps) is laundered at a commercial Laundromat, by contracted laundry service, or a washer and dryer on site. Manufacturer's guidelines are followed to decontaminate and launder reusable protective clothing. Laundry requirements are "not applicable" if only disposable PPE is used on site.

Section B	Medical Office/Clinic is compliant with OSHA Blood borne Pathogens and Waste Management Act.

Regulated Waste Storage: Regulated waste is contained separately from other wastes (e.g., contaminated wastes) at the point of origin in the producing facility, placed in red bio hazardous bags with Biohazard label, and stored in a closed container that is not accessible to unauthorized persons. Regulated wastes include: 1) Bio hazardous wastes, e.g., laboratory wastes, human specimens/tissue, blood/contaminated materials "known" to be infected with highly communicable diseases for humans and/or that require isolation, and 2) Medical wastes, e.g., liquid/semi-liquid blood or OPIM, items caked with dry blood or OPIM and capable of releasing materials during handling, and contaminated sharps (Health and Safety Code, Chapter 6.1, CA Medical Waste Management Act).

Note: Contaminated wastes include materials soiled with blood during the course of their use but are not within the scope of regulated wastes. Contaminated waste items need not be disposed as regulated waste in labeled red bags, but can be discarded as solid waste in regular trash receptacle.

Section C	Contaminated surfaces are decontaminated according to established regulations/ standards.

8 CCR §5193; CA H&S Code §118275

Routine Decontamination: Contaminated work surfaces are decontaminated with an appropriate disinfectant (29 CFR 1910.1030). Written cleaning an disinfection protocols/procedures/schedules are followed for **regular routine daily cleaning**. Staff is able to identify frequency for routine cleaning of surfaces and equipment, the disinfectant used and responsible personnel. Equipment is cleaned and disinfected per manufacturer recommendations.

Spill Procedure: Staff is able to identify procedures for prompt decontamination of blood/body fluid spills, the disinfectant used, and the responsible person(s).

Disinfectant Products: Products used for decontamination have a current EPA-approved status. Effectiveness in killing HIV/HBV/TB is stated on the manufacturer's product label. Decontamination products are reconstituted and applied according to manufacturer's guidelines for "decontamination." 10% Bleach Solution: 10% bleach solution is changed/reconstituted every 24 hours (due to instability of bleach once mixed with water). Surface is cleaned prior to disinfecting (due to presence of organic matter (e.g., dirt, blood, excrement) inactivates active ingredient, sodium hypochlorite). Surface is air dried or allowed appropriate time (stated on label) before drying. Manufacturer's directions, specific to every bleach product, are followed carefully.

Note: "Contamination" means the presence or reasonably anticipated presence of blood or OPIM on any item or surface. "Decontamination" is the use of appropriate physical or chemical means to remove, inactivate or destroy blood borne pathogens so that a surface or item is no longer capable of transmitting infectious particles and is rendered safe for handling, use or disposal.

Section D	Reusable medical instruments are properly sterilized after each use.

22 CCR §53230, §53856; CA H&S Code, Chapter 6.1, §25090

Cleaning prior to sterilization: Prior to undergoing the sterilization process, soiled instruments/equipment are thoroughly cleaned, rinsed, dried and inspected for the presence of dried blood or other debris. Personnel are able to demonstrate or verbally explain procedure(s) used for cleaning prior to sterilization, and to locate written directions on site.

Cold/chemical sterilization: Product manufacturer's directions are strictly followed for instrument pre-soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g., room temperature, area ventilation), and post- sterilization processes. Sterilization exposure times and solution expiration date/time is communicated to staff. Written procedures for cold sterilization are available on site to staff.

Autoclave/steam sterilization: Autoclave manufacturer's directions are strictly followed for instrument pre-cleaning, machine loading, operation safety precautions, minimum time-temperature criteria, and post sterilization processes. Written operating procedures for autoclave are available on site to staff. If instruments/equipment are transported off-site for sterilization, equipment- handling and transport procedures are available on site to staff.

Autoclave maintenance: Autoclave is maintained and serviced according to manufacturer's guidelines. If the manufacturer's guidelines are not present on site, the autoclave is serviced annually by a qualified technician. A dated sticker on the autoclave or a service receipt is acceptable documentation of appropriate maintenance.

Spore testing: Autoclave spore testing is performed at least monthly, unless otherwise stated in manufacturer's guidelines. Written procedures for performing routine spore testing and for handling positive spore test results are available on site to staff. For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. Procedures include: report problem, repair autoclave, retrieve all instruments sterilized since last negative spore test, re-test autoclave and re-sterilize retrieved instruments (Report/Repair/Retrieve/Retest/Re-sterilize).

Section D	Reusable medical instruments are properly sterilized after each use.

Documentation: Documentation of the following activities is maintained on site:
- Autoclave maintenance: mechanical problems, inspection dates, results/outcome of routine servicing, calibration, repairs, etc.,
- Sterilization loads: date, time and duration of run cycle, temperature, steam pressure, operator of each run,
- Biological spore testing: date, results, types of spore test used, person performing/documenting test results

Sterile Packages: Storage areas for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, and drawer). Sterilized package labels include date of sterilization, load run identification information, and general contents (e.g. suture set). Each item in a sterile package need not be listed on the label if a master list of package contents is available elsewhere on site. Maintenance of sterility is event related, not time related. Sterilized items are considered sterile until use, unless an event causes contamination. Sterilized items are not considered sterile if package is opened, wet/moist, discolored or damaged, and should be kept removed from sterile package storage area. Site has a process for routine evaluation of sterilized packages.

Note: Sterilization methods include autoclaves (steam under pressure), Ethylene Oxide (EO) gas sterilizer, dry-heat sterilizer, and liquid chemical sterilants. Biologic spore test products vary, and are designed for use based on specific autoclave type. Biologic control testing challenges the autoclave sterilization cycle with live, highly resistant, nonpathogenic spores. If spores are killed during processing, it is assumed that all other microorganisms are also killed and that the autoclave load is sterile.

Additional Comments:

SAMPLE

Reference Document: California Department of Services, Medi-Cal Managed Care Division

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Medical and Behavioral Health

Health Record Audit Tool

Practitioner Name: **Review Date:**

Practitioner Address: **Reviewer Name/Title:**

Contact Person/Title:

Visit Purpose
□ Monitoring
□ Corrective Action Plan -Follow Up
□ Other

Site Score		
1. Format	45 /	45
2. Documentation	40 /	40
3. Coordination/Continuity-of-Care	40 /	40
4. Preventive Care	10 /	10

Provider Type	
□ Family Practice	□ Internal Medicine
□ Pediatrics	□ OB-GYN
□ General Practitioner	□ Psychiatry
□ Non-Physician Mid-Level Practitioner	

Total	135 /	135
100%		

Clinic/Office Type	
□ Primary Care	□ BH Office
□ Community Clinic	
□ Other	N/A Surgical Center
□ Non-Physician Mid-Level Practitioner	

Performance Score
□ **Pass: 90% or above**
□ **Not Pass: 89% or below**
□ Corrective Action Plan Required
□ Other Follow-Up

Scoring Procedure
1) Site score is total point only. The site score is one (1) or zero (0), there are not half points (0.5) given.
2) Add points given in each section
3) Add total points given in each sections.
4) Adjust score for "N/A" criteria (if needed). Subtract "N/A" points from _____total points possible.
5)Divide total points given by _____ or by "adjusted" total rate.
6) Multiply by 100 to get the performance score.
7) **Calculate**

_____ ÷ _____ = x100 = _____

Point Given   Time/Adjusted Points   Performance Standard

Medical Record
Audit Tool

Section		Format Criteria	Yes	No	N/A	Audit Score	Score	Comment
A.	1	An individual medical record is established for each member.	x			1	1	
A.	2	Member identification is on each page.	x			1	1	
A.	3	Member personal biographical information is documented.	x			1	1	
A.	4	Emergency "contact" is identified.	x			1	1	
A.	5	Medical records are consistantly organized	x			1	1	
A.	6	Medical records are securely fastened, complete and secure	x			1	1	
A.	7	Patient's assigned primary care physician (PCP) is identified.	x			1	1	
A.	8	Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are documented.	x			1	1	
A.	9	Member's cultural needs are documented.	x			1	1	
		Total	9			9	9	

Section		Documentation Criteria	Yes	No	N/A	Audit Score	Score	Comment
B.	1	Allergies are prominently documented.	x			1	1	
B.	2	Chronic problems and/or significant conditions are listed.	x			1	1	
B.	3	Current medications are listed.	x			1	1	
B.	4	Signed informed consents are present, when appropriate.	x			1	1	
B.	5	Medical record documentation is complete	x			1	1	
B.	6	Advanced medical Care Directive information is offered. (Only: Adults, 18 years/older; Emancipated)	x			1	1	
B.	7	Additional Behavioral medical Record documentation required.	x			1	1	
B.	8	Medical record entries are in accordance with acceptable legal medical and VHP documentation standards	x			1	1	
		Total	8			8	8	

Section		Coordination/Continuity of Care Criteria	Yes	No	N/A	Score	Audit Score	Comment
C.	1	History of present illness is documented.	x			1	1	
C.	2	Working diagnoses or impression are consistent with clinical findings.	x			1	1	
C.	3	Treatment plans are consistent with diagnoses.	x			1	1	
C.	4	Instruction for follow-up care/medical education is documented.	x			1	1	
C.	5	Unresolved/continuing problems are addressed in subsequent visit(s).	x			1	1	
C.	6	A physician reviewed consult/referral reports and diagnostic test results.	x			1	1	
C.	7	Missed/cancelled appointments and follow-up contacts/outreach efforts are documented.	x			1	1	
C.	8	Advice by telephone, online or after-hours are documented.	x			1	1	
		Total	8			8	8	

Section		Preventive Care Audit Criteria (Not Applicable for Behavioral medical Record Audit)	Yes	No	N/A	Score	Audit Score	Comment
D.	1	Immunizations are documented.	x			1	1	
D.	2	Preventive care screenings are documented.	x			1	1	
		Total	2			2	2	

Comment: Write a comment for all "No" (0 points) and "N/A" scores.

Chart #1 Score	Audit Score		Score
1. Format	9	/	9
2. Documentation	8	/	8

3. Coordination/Continuity-of-Care	8	/	8
4. Preventive Care	2	/	2

Total | 27 / | 27

MEMBER ID:

Section		Format Criteria	Yes	No	N/A	Audit Score	Score	Comment
A.	1	An individual medical record is established for each member.	x			1	1	
A.	2	Member identification is on each page.	x			1	1	
A.	3	Member personal biographical information is documented.	x			1	1	
A.	4	Emergency "contact" is identified.	x			1	1	
A.	5	Medical records are consistantly organized	x			1	1	
A.	6	Medical records are securely fastened, complete and secure	x			1	1	
A.	7	Patient's assigned primary care physician (PCP) is identified.	x			1	1	
A.	8	Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are documented.	x			1	1	
A.	9	Member's cultural needs are documented.	x			1	1	
		Total	9			9	9	

Section		Documentation Criteria	Yes	No	N/A	Audit Score	Score	Comment
B.	1	Allergies are prominently documented.	x			1	1	
B.	2	Chronic problems and/or significant conditions are listed.	x			1	1	
B.	3	Current medications are listed.	x			1	1	
B.	4	Signed informed consents are present, when appropriate.	x			1	1	
B.	5	Medical record documentation is complete	x			1	1	
B.	6	Advanced medical Care Directive information is offered. (Only: Adults, 18 years/older; Emancipated)	x			1	1	
B.	7	Additional Behavioral medical Record documentation required.	x			1	1	
B.	8	Medical record entries are in accordance with acceptable legal medical and VHP documentation standards	x			1	1	
		Total	8			8	8	

Section		Coordination/Continuity of Care Criteria	Yes	No	N/A	Score	Audit Score	Comment
C.	1	History of present illness is documented.	x			1	1	
C.	2	Working diagnoses or impression are consistent with clinical findings.	x			1	1	
C.	3	Treatment plans are consistent with diagnoses.	x			1	1	
C.	4	Instruction for follow-up care/medical education is documented.	x			1	1	
C.	5	Unresolved/continuing problems are addressed in subsequent visit(s).	x			1	1	
C.	6	A physician reviewed consult/referral reports and diagnostic test results.	x			1	1	
C.	7	Missed/cancelled appointments and follow-up contacts/outreach efforts are documented.	x			1	1	
C.	8	Advice by telephone, online or after-hours are documented.	x			1	1	
		Total	8			8	8	

Section		Preventive Care Audit Criteria (Not Applicable for Behavioral medical Record Audit)	Yes	No	N/A	Score	Audit Score	Comment
D.	1	Immunizations are documented.	x			1	1	
D.	2	Preventive care screenings are documented.	x			1	1	
		Total	2			2	2	

Comment: Write a comment for all "No" (0 points) and "N/A" scores.

Chart #2 Score	Audit Score		Score
1. Format	9	/	9
2. Documentation	8	/	8

3. Coordination/Continuity-of-Care	8 /	8
4. Preventive Care	2 /	2

Total 27 / 27

MEMBER ID:

Section		Format Criteria	Yes	No	N/A	Audit Score	Score	Comment
A.	1	An individual medical record is established for each member.	x			1	1	
A.	2	Member identification is on each page.	x			1	1	
A.	3	Member personal biographical information is documented.	x			1	1	
A.	4	Emergency "contact" is identified.	x			1	1	
A.	5	Medical records are consistantly organized	x			1	1	
A.	6	Medical records are securely fastened, complete and secure	x			1	1	
A.	7	Patient's assigned primary care physician (PCP) is identified.	x			1	1	
A.	8	Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are documented.	x			1	1	
A.	9	Member's cultural needs are documented.	x			1	1	
		Total	9			9	9	

Section		Documentation Criteria	Yes	No	N/A	Audit Score	Score	Comment
B.	1	Allergies are prominently documented.	x			1	1	
B.	2	Chronic problems and/or significant conditions are listed.	x			1	1	
B.	3	Current medications are listed.	x			1	1	
B.	4	Signed informed consents are present, when appropriate.	x			1	1	
B.	5	Medical record documentation is complete	x			1	1	
B.	6	Advanced medical Care Directive information is offered. (Only: Adults, 18 years/older; Emancipated)	x			1	1	
B.	7	Additional Behavioral medical Record documentation required.	x			1	1	
B.	8	Medical record entries are in accordance with acceptable legal medical and VHP documentation standards	x			1	1	
		Total	8			8	8	

Section		Coordination/Continuity of Care Criteria	Yes	No	N/A	Score	Audit Score	Comment
C.	1	History of present illness is documented.	x			1	1	
C.	2	Working diagnoses or impression are consistent with clinical findings.	x			1	1	
C.	3	Treatment plans are consistent with diagnoses.	x			1	1	
C.	4	Instruction for follow-up care/medical education is documented.	x			1	1	
C.	5	Unresolved/continuing problems are addressed in subsequent visit(s).	x			1	1	
C.	6	A physician reviewed consult/referral reports and diagnostic test results.	x			1	1	
C.	7	Missed/cancelled appointments and follow-up contacts/outreach efforts are documented.	x			1	1	
C.	8	Advice by telephone, online or after-hours are documented.	x			1	1	
		Total	8			8	8	

Section		Preventive Care Audit Criteria (Not Applicable for Behavioral medical Record Audit)	Yes	No	N/A	Score	Audit Score	Comment
D.	1	Immunizations are documented.	x			1	1	
D.	2	Preventive care screenings are documented.	x			1	1	
		Total	2			2	2	

Comment: Write a comment for all "No" (0 points) and "N/A" scores.

Section		Format Criteria	Yes	No	N/A	Audit Score	Score	Comment
A.	1	An individual medical record is established for each member.	x			1	1	
A.	2	Member identification is on each page.	x			1	1	
A.	3	Member personal biographical information is documented.	x			1	1	
A.	4	Emergency "contact" is identified.	x			1	1	
A.	5	Medical records are consistantly organized	x			1	1	
A.	6	Medical records are securely fastened, complete and secure	x			1	1	
A.	7	Patient's assigned primary care physician (PCP) is identified.	x			1	1	
A.	8	Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are documented.	x			1	1	
A.	9	Member's cultural needs are documented.	x			1	1	
		Total	9			9	9	

Section		Documentation Criteria	Yes	No	N/A	Audit Score	Score	Comment
B.	1	Allergies are prominently documented.	x			1	1	
B.	2	Chronic problems and/or significant conditions are listed.	x			1	1	
B.	3	Current medications are listed.	x			1	1	
B.	4	Signed informed consents are present, when appropriate.	x			1	1	
B.	5	Medical record documentation is complete	x			1	1	
B.	6	Advanced medical Care Directive information is offered. (Only: Adults, 18 years/older; Emancipated)	x			1	1	
B.	7	Additional Behavioral medical Record documentation required.	x			1	1	
B.	8	Medical record entries are in accordance with acceptable legal medical and VHP documentation standards	x			1	1	
		Total	8			8	8	

Section		Coordination/Continuity of Care Criteria	Yes	No	N/A	Score	Audit Score	Comment
C.	1	History of present illness is documented.	x			1	1	
C.	2	Working diagnoses or impression are consistent with clinical findings.	x			1	1	
C.	3	Treatment plans are consistent with diagnoses.	x			1	1	
C.	4	Instruction for follow-up care/medical education is documented.	x			1	1	
C.	5	Unresolved/continuing problems are addressed in subsequent visit(s).	x			1	1	
C.	6	A physician reviewed consult/referral reports and diagnostic test results.	x			1	1	
C.	7	Missed/cancelled appointments and follow-up contacts/outreach efforts are documented.	x			1	1	
C.	8	Advice by telephone, online or after-hours are documented.	x			1	1	
		Total	8			8	8	

Section		Preventive Care Audit Criteria (Not Applicable for Behavioral medical Record Audit)	Yes	No	N/A	Score	Audit Score	Comment
D.	1	Immunizations are documented.	x			1	1	
D.	2	Preventive care screenings are documented.	x			1	1	
		Total	2			2	2	

Comment: Write a comment for all "No" (0 points) and "N/A" scores.

Section		Format Criteria	Yes	No	N/A	Audit Score	Score	Comment
A.	1	An individual medical record is established for each member.	x			1	1	
A.	2	Member identification is on each page.	x			1	1	
A.	3	Member personal biographical information is documented.	x			1	1	
A.	4	Emergency "contact" is identified.	x			1	1	
A.	5	Medical records are consistantly organized	x			1	1	
A.	6	Medical records are securely fastened, complete and secure	x			1	1	
A.	7	Patient's assigned primary care physician (PCP) is identified.	x			1	1	
A.	8	Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are documented.	x			1	1	
A.	9	Member's cultural needs are documented.	x			1	1	
		Total	9			9	9	

Section		Documentation Criteria	Yes	No	N/A	Audit Score	Score	Comment
B.	1	Allergies are prominently documented.	x			1	1	
B.	2	Chronic problems and/or significant conditions are listed.	x			1	1	
B.	3	Current medications are listed.	x			1	1	
B.	4	Signed informed consents are present, when appropriate.	x			1	1	
B.	5	Medical record documentation is complete	x			1	1	
B.	6	Advanced medical Care Directive information is offered. (Only: Adults, 18 years/older; Emancipated)	x			1	1	
B.	7	Additional Behavioral medical Record documentation required.	x			1	1	
B.	8	Medical record entries are in accordance with acceptable legal medical and VHP documentation standards	x			1	1	
		Total	8			8	8	

Section		Coordination/Continuity of Care Criteria	Yes	No	N/A	Score	Audit Score	Comment
C.	1	History of present illness is documented.	x			1	1	
C.	2	Working diagnoses or impression are consistent with clinical findings.	x			1	1	
C.	3	Treatment plans are consistent with diagnoses.	x			1	1	
C.	4	Instruction for follow-up care/medical education is documented.	x			1	1	
C.	5	Unresolved/continuing problems are addressed in subsequent visit(s).	x			1	1	
C.	6	A physician reviewed consult/referral reports and diagnostic test results.	x			1	1	
C.	7	Missed/cancelled appointments and follow-up contacts/outreach efforts are documented.	x			1	1	
C.	8	Advice by telephone, online or after-hours are documented.	x			1	1	
		Total	8			8	8	

Section		Preventive Care Audit Criteria (Not Applicable for Behavioral medical Record Audit)	Yes	No	N/A	Score	Audit Score	Comment
D.	1	Immunizations are documented.	x			1	1	
D.	2	Preventive care screenings are documented.	x			1	1	
		Total	2			2	2	

Comment: Write a comment for all "No" (0 points) and "N/A" scores.

Purpose: Medical Record Audit Guidelines provide standards for the medical record audit, and shall be used for measuring, evaluating, assessing, and making decisions.

Scoring: Audit score is based on a review standard of five (5) records per individual practitioner. Documented evidence found in the hard copy (paper) medical records and/or electronic medical records are used for audit criteria determinations. Pass is 90% and above. Not Pass is 89% and below and a corrective action plan is required. Not applicable ("N/A") applies to any criterion that does not apply to the medical record being reviewed, and must be explained in the comment section of the medical record audit tool. Medical records shall be randomly selected. Office/Clinic sites where documentation of patient care by all Primary Care Physician (PCPs) on site occurs in universally shared medical records shall be reviewed as a "shared" medical record system. Scores calculated on shared medical records apply to each PCP sharing the records. A minimum of ten shared medical records shall be reviewed for 2-3 PCPs, twenty records for 4-6 PCPs, and thirty records for 7 or more PCPs.

Score one point if criterion is met. Score zero points if criterion is not met. Do not score partial points for any criterion. When10 shared records are reviewed, score calculation shall be the same as for 10 records reviewed for a single practitioner. If 20 medical records are reviewed, divide total points given by 27 or by the "adjusted" total points possible. If 30 medical records are reviewed, divide total points given by 27 or by the "adjusted" total points possible. Multiply by 100 to calculate percentage rate. Reviewers have the option to request additional records to review, but must calculate scores accordingly.

FORMAT	
Section A	**Reviewer Guidelines**
A.1	Practitioner are able to readily identify each individual treated. A medical record is started upon the initial visit. "Family charts" are not acceptable.
A.2	Member identification includes first and last name, and/or a unique patient number established for use on clinical site. Electronically maintained records and printed records from electronic systems contain member identification.
A.3	Personal biographical information includes date of birth, gender, current address, home phone numbers, employment – if applicable, marital status, and name of parent(s) if member is a minor/conservator/ responsible party to sign consent(s). If member refused to provide information, "refused" is noted in the medical record. If portions of the personal biographical information are not completed (left blank), reviewer should attempt to determine if member has refused to provide information. Do not deduct points if member has refused to provide all personal information requested by the provider.
A.4	The name and phone number of an "emergency contact" person is identified for all patients. Listed emergency contacts may include a relative or friend, or a home, work, pager, cellular or message phone number. If the patient is a minor or conservator, the contact person must be a parent/legal guardian/conservator. Adults and emancipated minors may list anyone of their choosing. If a patient refuses to provide an emergency contact, "refused" is noted in the record. **Do not deduct points if member has refused to provide personal information requested by the practitioner.**
A.5	Contents and format of printed and/or electronic records within the practice site are uniformly organized. There are no missing pages and the pages are in chronological order.
A.6	Printed chart contents are securely fastened, attached or bound to prevent medical record loss. Electronic and paper medical record information is readily available. The medical record content and format are uniform and consistent with the organization's medical record policies. If applicable, medical records of the member being treated elsewhere or transferred to another medical care provider/practitioner are present. The medical record is organized, legible, easily accessed and in a secure format only accessible by authorized personnel. The medical record is maintained against unauthorized disclosure of confidential information.
A.7	The assigned PCP is always identified on the chart.
A.8	The primary language and requests for language and/or interpretation services by a non-or limited-English proficient person is documented. Member will be offered access to interpreter services at no cost to the member. **VHP's policy discourages the use of family members, friends and minors as interpreters (COM 1921 VHP Language Assistance Program).** Member refusal of interpreter services is documented. If English is the primary language, it should also be documented.
A.9	The members' cultural needs (the ability to respond to an individuals' attitudes, feelings, or circumstances related to their racial, national, religious, linguistic or cultural heritage) are documented, when needed.

DOCUMENTATION	
Section B	**Reviewer Guidelines**
B.1	Allergies and adverse reactions are listed in a consistent location in the medical record. The presence or absence of allergies and untoward reactions to drugs or materials is recorded in a prominent and consistent location, verified at each patient encounter, and updated when new allergies or sensitivities are identified. If member has no allergies or adverse reactions, "No Known Allergies" (NKA), "No known Drug Allergies" (NKDA), or is documented.
B.2	Documentation may be on a separate "problem list" page, or a clearly identifiable problem list in the progress notes. All chronic or significant problems are considered current if no "end date" is documented.
B.3	Documentation may be on a separate "medication list" page, or a clearly identifiable medication list in the progress notes. The medical record reflects a current review and medication are updated at each visit (reconcile). List of current, on-going medications identifies the medication name, strength, dosage, route, frequency, start/stop dates whether prescription or non-prescription, which includes dietary supplements. Discontinued medications are noted on the medication list or in progress notes.
B.4	Adults, parents/legal guardians of a minor or emancipated minors may sign consent forms for medical treatment. Informed consents are signed for medical (e.g. operative/invasive procedures) and behavioral medical services. Signed authorization is documented in the medical record for release of medical information. Note: Persons under the age of 18 years are emancipated if they have entered into a valid marriage, are on military active duty, or have received a court declaration of emancipation under the CA Family Code, Section 7122.
B.5	If applicable, the medical record reflects discussion with the member concerning the necessity, appropriateness, and risks of proposed care, surgery, or procedures, as well as discussions of treatment alternatives. Past medical history is recorded and easily identified, including serious accidents, operations, and illnesses. For medical records with multiple visits/admissions OR complex and lengthy records, diagnostic summaries are utilized in accordance with organization polices and procedure. For children, past medical history also includes birth information and mother's prenatal – if available. In pediatric medical record aged 13 years and under, plotted growth charts and documentation of developmental milestones are documented. For members over 14 years and older, assessment for potential substance abuse, which includes: smoking, alcohol, prescription medications, non-prescription medications (over-the-counter), including dietary supplements. If applicable, research activity will be documented separately from non-research.
B.6	Adult (18 years and Emancipated minors) medical records include documentation of whether member has been offered information or has executed an Advance medical Care Directive (California Probate Code, Sections 4701). The record reflects discussion with the member. If the member does not wish to talk about their advance directive, it is to be noted in the record.
B.7	All entries are signed, dated and legible. The department should be identified, if departmentalized. Signature includes the first initial, last name and title. Initials may be used only if signatures are specifically identified elsewhere in the medical record (e.g. signature page). Stamped signatures are acceptable, but must be authenticated. Date includes the month/day/year. Only standard abbreviations are used. Entries are in reasonable consecutive order by date. Handwritten documentation, signatures and initials are entered in blue or black ink (VHP Policy – COM 6004). Handwritten documentation does not contain skipped lines or empty spaces where information can be added. Entries are not backdated or inserted into spaces above previous entries. Omissions are charted as a new entry. Late entries are signed and dated.
B.8	Additional documentation required for a behavioral medical record: • HIPPA disclosure form is maintained in the medical record. • Complete Mental medical Exam which may include: affect, speech, mood, thought content, judgment, insight, attention/concentration, memory and impulse control • Risk Factors, which may include: imminent risk of harm, physical, sexual abuse or neglect, aggressive, violent, self-destructive/suicidal behavior for client/family noted.

COORDINATION/CONTINUITY OF CARE	
Section C	**Reviewer Guidelines**
C.1	Each visit is dated and includes a documented history of present illness or primary complaint or purpose of visit.
C.2	At each visit, the chief compliant or purpose of visit is identified. Each visit has a documented "working" diagnosis/impression derived from a physical exam, and/or "Subjective" information such as chief complaint or reason for the visit as stated by member/parent/conservator. "Objective" information such as assessment findings and conclusion that is documented relate to the working diagnoses. The diagnosis is appropriate for the findings in the current history and physical exam. Additional documentation required for a behavioral medical record: • DSM IV Diagnosis Axis I-V present
C.3	A plan of treatment and care includes: medical studies (laboratory tests, imaging, ancillary service, consultation/referral and behavioral medical, as needed. The treatment, diagnostic, and therapeutic procedures are consistent with clinical impression or working diagnosis. There is documentation care was rendered and therapies administered. If applicable, the medical record documentation includes discussions with the patient concerning the necessity, appropriateness, and risks of proposed care, surgery, or procedure, as well discussion of treatment alternatives. Additional documentation required for a behavioral medical record: • The treatment plan estimated time frames for goal attainment or problem resolution • Member's understanding of the treatment plan.
C.4	Disposition, recommendation, and instructions given to member. Specific follow-up instructions and a definite time for return visit or other follow-up care is documented. Time for return visits or other follow-up care is definitively stated in number of days, weeks, months, or as needed. There is documentation the member received education, training and instruction or discussion on their medical condition, treatment plan and/or preventive care, as needed
C.5	Previous complaints and unresolved or chronic problems are addressed in subsequent notes until problems are resolved or a diagnosis is made. Each problem need not be addressed at every visit. Documentation demonstrates that provider follows up with patients about treatment regiments, recommendations, counseling, and/or referrals.
C.6	Studies ordered such as, lab tests, X-ray reports, consultation summaries, inpatient/discharge records, operative reports, emergency and urgent care reports, and all abnormal and/or "STAT" reports show documented evidence of physician review and filed in the record in a timely manner. Evidence of review may include the physician's initials or signature on the report, notation in the progress notes, or other site-specific method of documenting physician review. Abnormal test results/diagnostic reports have explicit notation in the medical record. Documentation includes patient contact or contact attempts, follow-up treatment, instructions, return office visits, referrals and/or other pertinent information. Electronically maintained medical reports must also show evidence of physician review, and may differ from site to site. There is evidence of continuity and coordination of care between the PCP and Behavioral medical practitioner/behavioral medical practitioners, when applicable.
C.7	Documentation includes incidents of missed/broken appointments (cancellations or "No shows") for PCP examinations, diagnostic procedures, lab tests, specialty appointments, and/or other referral services. Attempts to contact the member and/or parent/guardian (if minor)/conservator, and the results of follow-up actions are documented.
C.8	Significant medical advice provided by telephone, online or after-hours is entered in the medical record and appropriately signed or initialed. This includes the Medical Advice Line, as appropriate.
Preventive Care	
Section D	**Reviewer Guidelines**
D.1	There is documentation of immunization status and/or immunizations administered for all age groups. Documentation for immunizations administered includes: lot number, date, time, site and education given member or parent/conservator – when appropriate. **Note:** There is a link on the VHP Website to the Center for Disease Control and Prevention (CDC) Immunization Schedules.
D.2	There is documentation that preventive screening and services are offered. **Note:** There is a link to the United States Prevention Task Force Clinical Recommendations USPSTF Clinical Recommendation on the VHP Website.

Reference: California Department of Services, Medi-Cal Managed Care Division

Member Rights and Responsibilities

A Member has the right to:

1. Exercise these rights without regard to race, color, national origin, age, religion, disability, sex, sexual orientation, gender identity, gender expression, creed, family history, marital status, veteran status, national origin, handicap, or condition, without regard to your cultural, economic, or educational background, or source(s) of payment for your care, or any other classification prohibited by state or federal laws.
2. Be treated with dignity, respect, consideration, and your right to privacy.
3. Expect health care providers (doctors, medical professionals, and their staff) to be sensitive to your needs.
4. Be provided with information about VHP, its services, and Plan Providers and member rights and responsibilities;
5. Know the name of the Primary Care Physician who has primary responsibility for coordinating your health care and the names and professional relationships of other Plan Providers you see.
6. Actively participate in your own health care, which to the extent permitted by law, includes the right to receive information so that you can accept or refuse recommended treatment.
7. Receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse this course of treatment or procedure. Except for Emergency Services this information will include a description of the procedure or treatment, the medically significant risks involved, alternative courses of action and the risks involved in each, and the name of the Plan Provider who will carry out the treatment or procedure.
8. Full consideration of privacy concerning your course of treatment. Case discussions, consultations, examinations, and treatments are confidential and should be conducted discreetly. You have the right to know the reason should any person be present or involved during these procedures or treatments.
9. Confidential treatment of information in compliance with state and federal law including HIPAA (including all communications and medical records) pertaining to your care. Except as is necessary in connection with administering the Agreement and fulfilling State and federal requirements (including review programs to achieve quality and cost-effective medical care), such information will not be disclosed without first obtaining written permission from you or your authorized representative
10. Receive complete information about your medical condition, any proposed course of treatment, and your prospects for recovery in terms that you can understand.
11. Give informed consent unless medically inadvisable, before the start of any procedure or treatment.
12. Refuse health care services to the extent permitted by law and to be informed of the medical consequences of that treatment, unless medically inadvisable.
13. Readily accessible and ready referral to Medically Necessary Covered Services.
14. A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage
15. A second medical opinion, when medically appropriate, from another Plan Physician within your VHP Provider Network.
16. Be able to schedule appointments in a timely manner.

17. Reasonable continuity of care and advance knowledge of the time and location of your appointment(s).
18. Reasonable responses to any reasonable requests for Covered Services.
19. Have all lab reports, X-rays, specialist's reports, and other medical records completed and placed in your files as promptly as possible so that your Primary Care Physician can make informed decisions about your treatment.
20. Change your Primary Care Physician.
21. Request and expedited change of a provider due to medical necessity
22. Review your medical records, unless medically inadvisable.
23. Be informed of any charges (Co-payments) associated with Covered Services.
24. Be advised if a Plan Provider proposes to engage in or perform care or treatment involving experimental medical procedures, and the right to refuse to participate in such procedures.
25. Leave a Plan Facility or Hospital, even against the advice of Plan Providers.
26. Be informed of continuing health care requirements following your discharge from Plan Facilities or Hospitals.
27. Be informed of, and if necessary, given assistance in making a medical Advance Health Care Directive.
28. Have rights extended to any person who legally may make decisions regarding medical care on your behalf.
29. Know when Plan Providers are no longer under a contractual arrangement with VHP.
30. Examine and receive an explanation of any bill(s) for non-Covered Services, regardless of the source(s) of payment.
31. File a Grievance without discrimination through VHP or appropriate State or federal agencies.
32. Know the rules and policies that apply to your conduct as a Member.
33. Participate with practitioners in making decisions about your health.
34. Know Provider credentials are available by request or through the provider directory.
35. Receive information regarding malpractice insurance on providers upon request.

A Member has the responsibility to:
1. Provide complete & accurate information (to extent possible) that VHP and its practitioners/providers need in order to provide care. Inform practitioner/provider about any health issues, medications, and allergies. This information should also include living will, medical power of attorney, or other directive that could affect care
2. Follow plans and instructions for care that you have agreed to with your practitioner
3. Accept fiscal responsibility for any cost of share, such as Premiums, Deductibles, Coinsurance, or Copayments.
4. Accept fiscal responsibility associated with non-Covered Services. Covered Services are available only through Plan Providers in your VHP Network (unless such care is rendered as worldwide Emergency Services or is Prior Authorized).
5. Adhere to behavior that is reasonably supportive of therapeutic goals and professional supervision as specified.
6. Treat healthcare providers, staff, and others with respect to prevent any interference with your Plan Provider or their ability to provide care.

7. Cooperate with VHP or a Plan Provider's third-party recovery efforts or Coordination of Benefits
8. Safeguard the confidentiality of your own personal health care as well as that of other Members.
9. Cooperate with VHP or a Plan Provider's third-party recovery efforts.
10. Participate in your health care by scheduling and keeping appointments with Plan Providers. If you cannot keep your appointment, call in advance and reschedule or cancel.
11. Report any changes in your name, address, telephone number, or your family's status to status to your employer, Covered California, and a VHP Member Services Representative.
12. Inform your provider if you have a living will, medical power of attorney, or other directives affective care.
13. Understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible

Prior Authorization Guidelines for VHP Members

This table below reflects services that *require* prior authorization and is not intended to be a comprehensive list of covered services. For a complete list of covered benefits, providers should refer to the appropriate Evidence of Coverage (EOC), available online at www.valleyhealthplan.org.

Category of Service	Services Requiring Prior Authorization
Behavioral Health	• Applied Behavior Analysis (ABA) Services • Electroconvulsive Therapy (ECT) • Intensive Outpatient Program (IOP) • Psychiatry • Psychological Testing
Durable Medical Equipment (DME)[1]	• Bone stimulators • Breast pump • Baclofen Pump, Insulin Pump, Continuous Glucose Monitoring Device (CGM) and Supplies • Customized DME (e.g., Diabetic Shoes, Compression Sleeves) • DME Repair Services • Formula and Enteral Therapy • Hearing Aids and Hearing Aid Repairs • Hospital Bed and Mattress • Medical Equipment and Supplies (e.g., IV Pole, Syringes, Catheters, Wound Care Supplies) • Mobility Devices and Accessories (e.g., Power Wheelchairs, Scooters, Manual Wheelchairs, Motorized Wheelchairs, Cushion, Foot and Head Rests) • Negative Pressure Wound Therapy System or Wound Vac • Other Specialty Devices (e.g., Speech Generating Device) • Prosthetics and Orthotics • Respiratory Equipment and Supplies (e.g., Oxygen, Bilevel Positive Airway Pressure (BiPAP), Continuous Positive Airway Pressure (CPAP), Ventilators, Airway Clearance Vest) • Vision Aids as treatment for Aniridia and Aphakia
Experimental/Investigational Treatment, Procedures and Drugs	• Clinical Trials[2] • Investigational and Experimental Drug Therapies • Investigational and Experimental Procedures • New Technologies non-FDA approved for use (e.g., Robotic surgery) • Non-FDA approved and/or off-label use
Home Health/Hospice	• All Home Health Services (Registered Nurse, Physical, Speech and Occupational Therapists, Home Health Aide, etc.)

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[1] No prior authorization is required if VHP is secondary coverage; however, the Explanation of Benefit (EOB) must be attached to the claim for processing based on Coordination of Benefit (COB).

[2] Request must include the investigational protocol that sets forth the trial information and medical expenses to be incurred by VHP.

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Category of Service	Services Requiring Prior Authorization
	• Home Intravenous (IV) Infusions • Hospice Services

Inpatient Admissions	• All Admissions for:
	   o Acute Inpatient Psychiatric
	   o Partial Hospital Psychiatric
	   o Residential Mental Health
	   o Substance Use Disorder, including Detoxification
	• All Elective Inpatient Admissions to:
	   o Acute Care Hospitals
	   o Long Term Acute Care (LTAC)
	• Rehabilitation and Therapy Services:
	   o Acute Inpatient Rehabilitation or Acute Rehabilitation Unit (AIR/ARU)
	   o Skilled Nursing Facilities (SNFs)
	   o Subacute Nursing Facilities

Medications	• Infusion Services • Injections (excluding Immunizations) • Non-Formulary Prescription Drugs
Non-Contracted Providers, Tertiary Providers, and/or Quaternary Providers	• All Non-Urgent/Non-Emergent Services rendered by Non-Contracted Providers, Tertiary Providers, and/or Quaternary Providers such as Lucile Packard Children's Hospital, Stanford Children's Health, Stanford Health Care, and Stanford Hospital & Clinics

Outpatient Services and Procedures	• Acupuncture and Chiropractic Services
	• All Outpatient Procedures (e.g., Amniocentesis, Nerve Conduction Studies, Varicose Vein Treatment, Performed Outside of a Physician's Office, Endoscopy and Colonoscopy)
	• All Outpatient Surgery (e.g., Cataract Surgery, Tonsillectomy, Abdominoplasty, Panniculectomy, Breast Reduction and Augmentation Surgery)
	• Automated External Defibrillator (AED), Holter, Mobile Cardiac Telemetry Monitoring Services
	• CAR T-cell Therapy
	• Cardiac and Pulmonary Rehabilitation
	• Chemotherapy and Radiation Treatment (e.g., Brachytherapy, Neutron Beam Therapy, Proton Beam Therapy, Intensity-Modulated Radiation Therapy (IMRT), Stereotactic Body Radiation Therapy (SBRT), Stereotactic Radiosurgery (SRS), Gamma-ray and CyberKnife)
	• Dental Surgery, Dental Anesthesiology Service, Jaw Surgery and Orthognathic Procedures
	• Diagnostic Imaging:
	   o Bone Density (DEXA Scan)
	   o Computerized Tomography Scans (CT)
	   o Magnetic Resonance Angiography (MRA)

Category of Service	Services Requiring Prior Authorization
	o Magnetic Resonance Imaging (MRI) o Nuclear Cardiology Procedures (Stress Tests/Treadmill) o Positron-Emission Tomography (PET/PET-CT) o Single-Photon Emission Computerized Tomography (SPECT) • Dialysis: All Hemodialysis and Peritoneal, Continuous Ambulatory Peritoneal Dialysis (CAPD), Automated Peritoneal Dialysis (APD), Continuous Cycling Peritoneal Dialysis (CCPD) • Gender Reassignment Therapy and Surgery • Genetic Testing and Counseling • Hyperbaric Oxygen Therapy • Infertility Services • Non-routine Laboratory, Ultrasound and Radiology Services[3] • Outpatient Therapies (Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST)) • Pain Management Services • Palliative Care Services • Reconstructive Procedures • Second Opinions • Sleep Studies • Spinal Procedures, including all Injections • Surgical Implants (e.g., Pacemaker, Baclofen Pump, Neuro and Spinal Cord Stimulators, Cochlear Auditory Implant) • Temporomandibular Disorder (TMJ) Treatment • Unclassified Procedures • Ventricular Assist Device
Transplants	• All Transplants and Related Services
Non-Emergency Medical Transportation: Non-Interfacility	• Non-Emergency Medical Transport (NEMT), including Fixed-Wing Air Transport[4]
Other	• All Non-Urgent/Non-Emergent Services Performed Out-of-Area • All Non-Covered Services • All services not covered by the member's primary insurance in which VHP is secondary coverage • Any services that exceed the benefit limit

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[3] No authorization is required from VHP if routine labs and/or x-rays are performed pursuant to an approved authorization for a consultation within the member's primary network. If routine labs and/or x-rays are required for an authorized 2nd opinion consultation, labs and/or x-rays should be obtained from the physician performing the initial diagnostic evaluation.

[4] NEMT must be billed with the appropriate modifier.