PROVIDER BULLETIN

A Message from
Ghislaine Guez, MD, MBA, VHP Chief Medical Officer

As winter nears, and as the flu season begins in the midst of the COVID-19 pandemic, VHP's medical management team has taken on a variety of endeavors to keep our members healthy and give providers the resources and support that they need to do the same. In this multi-phased approach, the team has implemented strategies to improve efficiency, better connect with our members, and support our provider network.

Utilization Management Restructure: Timeliness is Essential

In an effort to improve authorization processing times and decrease the administrative burden on providers, VHP's UM team has transitioned a large number of medical product and service requests (that previously required prior-authorization review by a nurse) with notification only. For example, VHP automatically approves specialty referrals within a member's chosen network.

To improve efficiency, we also modified our UM nursing team structure. UM is now subdivided into two distinct groups: prior authorization and concurrent review. With the teams working in two separate capacities, nurses are more specialized with the goal of reduced turnaround times for authorizations and improved management of our members' in-hospital stays.

Flu Vaccination Campaign: Getting the Word Out

VHP's medical management and marketing teams have worked to align messaging with the County of Santa Clara and communicate with members and providers about free flu vaccination opportunities within the community. We have expanded member reimbursement for out-of-network pharmacy flu vaccinations

keep reading on the next page

and have encouraged vaccinations in both our Member Advisory Committee meeting and in the member newsletter. The Flu Fighter promotional campaign is live on VHP's website. Find it here: **www.valleyhealthplan.org/sites/m/hw/Pages/Flu.aspx.**

COVID Outreach: Talking to Our Members

Early in the pandemic, VHP identified members who were considered high-risk for more serious adverse outcomes and made calls to these members to talk about ways to stay safe: the importance of social distancing and mask use, frequent hand washing, and staying optimistic despite the drastic changes that limit individuals' normal social supports. During our outreach we also shared helpful tips on how and where to access our 24/7 Nurse Advice Line, registering and scheduling MDLive telehealth appointments, as well as shared community resources for emergency support (emergency bill pay, food pantries, shelter information, and more). This is one of the many ways VHP takes extra steps to help you care for your patients.

Moving Ahead: Connecting to Care

As the pandemic continues, VHP is planning outreach that will encourage members to seek routine preventive care that has been missed due to the local shelter-in-place order or postponed indefinitely given concerns about the risks of contracting COVID-19. Routine vaccinations for children and adults, as well as routine screenings such as mammograms and colonoscopies, are essential, and VHP will continue to focus on working with members and providers to get patients to care and to close these gaps.

The medical management team is now providing complex case management and condition case management (chronic disease-related case management services) to its members. VHP is no longer using the services of a delegated third party to provide these services. If you have a member who needs additional support, call **1.855.624.5223 (toll-free)** or email **VHPCaseMgmt@vhp.sccgov.org**, to connect them to a nurse case manager, social worker, or care coordinator. This skilled multidisciplinary team works to educate patients about the health system, to direct members to local services, connect them to behavioral health, and to support and advocate for their needs.

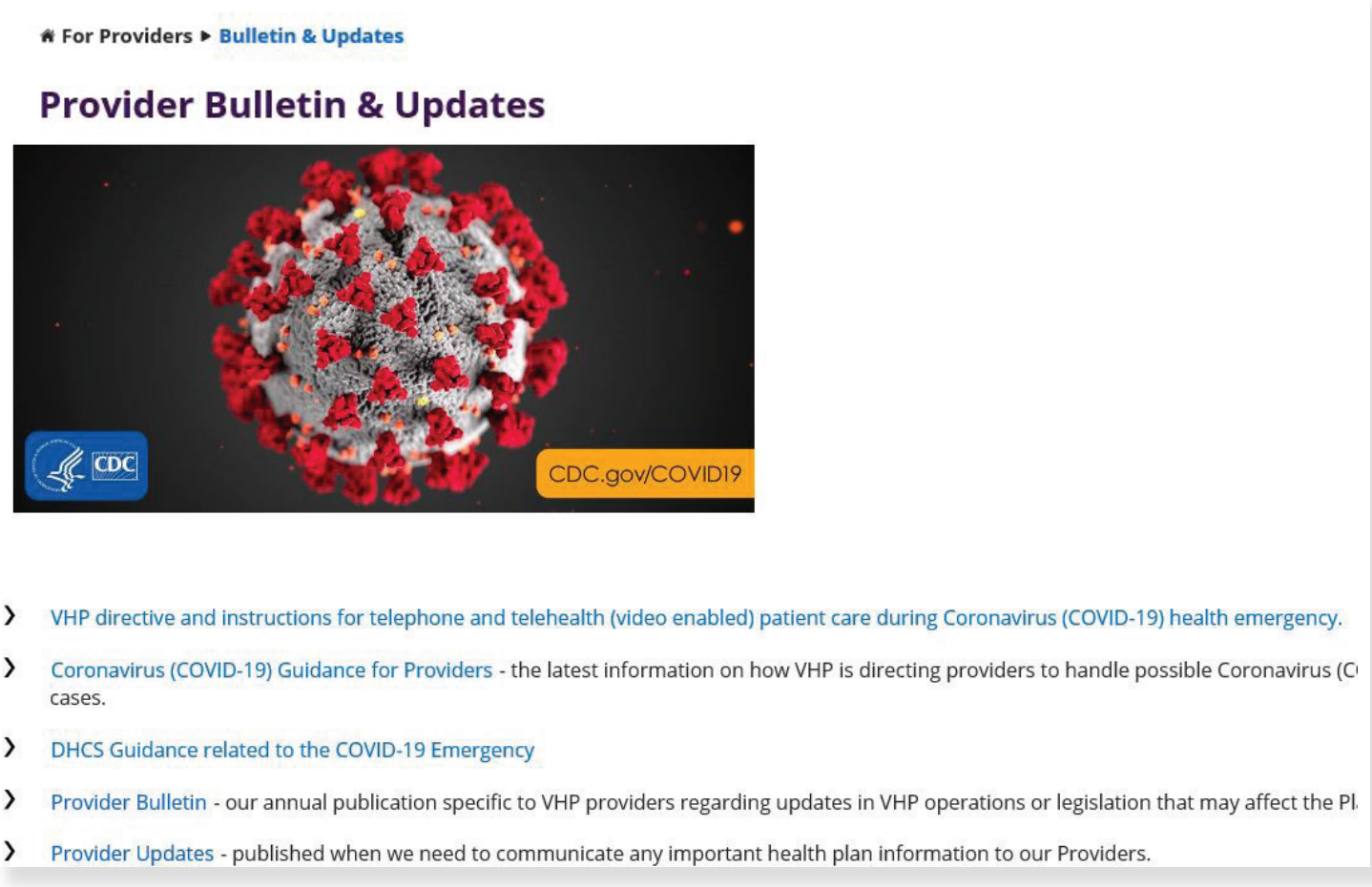
These initiatives have been designed to support our members - your patients - during this challenging time. From all of us here at VHP, we appreciate and respect all that you do to ensure our members receive the care they need. VHP's medical management team is here to not only work with you, but to support you as well – let us know how we can help.

Stay healthy and safe,

Gilly

(Ghislaine Guez, MD, MBA)

Staying Informed During COVID-19



VHP is dedicated to ensuring our provider partners are updated with information related to COVID-19 from the federal, state, and local levels, including the processes for the billing of COVID-19 related services. VHP will continue to send out Provider Updates via fax blast and post Provider Updates and other COVID-19 related information to the VHP website at: **www.valleyhealthplan.org/sites/p/Bulletin-and-Updates**

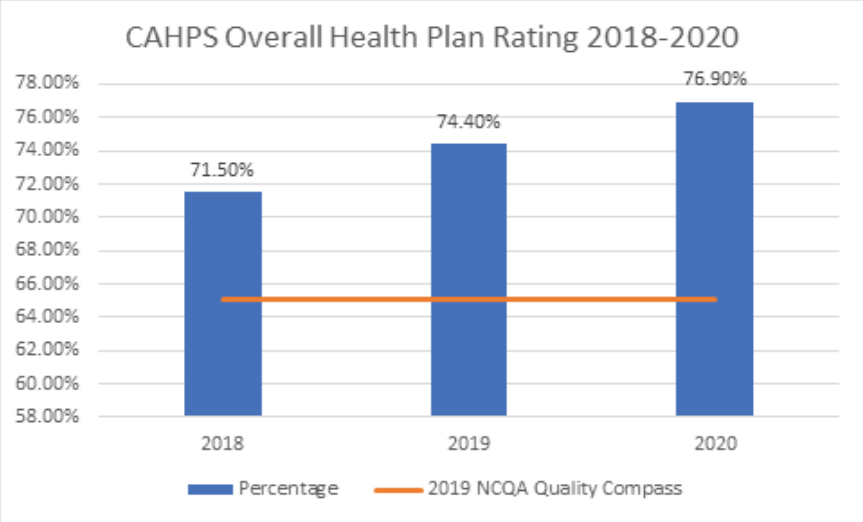
VHP's CAHPS, QHP, and QRS Ratings

Annually, VHP conducts the Consumer Assessment Healthcare Providers and Systems (CAHPS) Survey and Qualified Health Plan (QHP) Member Experience Survey (QHP Experience Survey) in accordance with the Centers for Medicare & Medicaid Services (CMS) regulations. The CAHPS survey represents both our Employer Group Experience and the QHP Member Experience Survey, which includes our Covered California member experience. The surveys are standardized tools and ask questions about the quality of care members receive.

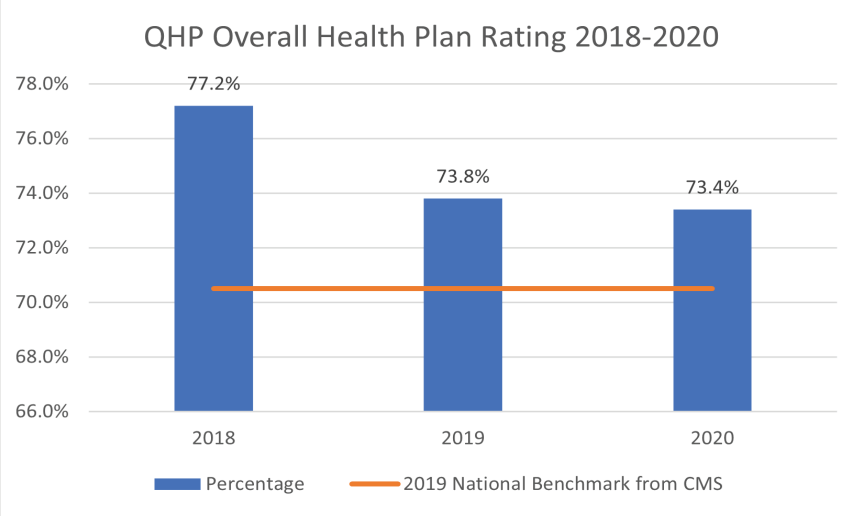
VHP consistently performs better on clinical quality measures than member experience quality measures. Over the last three years, we have had excellent health plan ratings that are above the national average. Every year VHP strives to find data driven solutions to enhance members' health care experience.

The blue columns indicate how VHP scored each year. The orange line represents the 2019 National Committee for Quality Assurance (NCQA) Quality Compass benchmark.

CAHPS Health Plan Rating (Commercial Employer Group and Covered California)



QHP Health Plan Ratings (Covered California)[1]



QRS Star Rating

The Quality Rating System (QRS) is a star rating that shows Covered California QHP's quality performance. Covered California QHPs are rated on a scale of one to five stars. The QRS star rating is a way to compare the quality scores between health plans participating in the Covered California Health Insurance Exchange. The QHP survey is used in combination with clinical quality measures - Healthcare Effectiveness Data and Information Set (HEDIS) - to create our Covered California QRS score. This year VHP received three stars as our overall Covered California global rating as a QHP.

Our Valued Partnership with Providers

VHP strives for continuous improvement in the quality of services we offer through our provider network and in the satisfaction that our members have with their health care experience. VHP has increased staff dedicated to network development and will continue to build its network of quality providers, as well as focusing on increasing the array of specialty services available to providers for referral. Recently VHP has undergone an organizational-wide CAHPS and QHP training to increase our capacity to improve our member experience. VHP recognizes that our providers are key to patient-centered care. We thank you for your consistent performance and look forward to collaborating on improvement strategies.

Quality Management (QM) Program

VHP's Quality Management Program's goal is to ensure our members receive high-quality care and service wherever they access care. The team accomplishes this by ensuring standards and regulations are followed by caregivers, by addressing member satisfaction concerns, access to care, as well as ongoing monitoring for anti-fraud activities and member grievances. The team regularly monitors potential quality issues, assesses member population needs, and unusual risk occurrences.

Targeted Efforts in 2020

- Improving HEDIS performance measures to accurately reflect the high-quality care that is provided to our members by our providers.
- Enhancing provider education on HEDIS performance measures so that there is alignment with VHP priorities, improvement in documentation, and a standard approach to preventive care and screening.
- Ensuring excellent care without delay and addressing opportunities for improvement by providing quality assurance monitoring of potential quality issues.
- Preparing for Accreditation Association for Ambulatory Health Care (AAAHC) accreditation.

HEDIS Measures and VHP Initiatives

HEDIS is a set of standardized performance measures designed to ensure health care consumers have access to reliable information. This data can be used by the consumer to compare performance among health plans. VHP monitors and tracks HEDIS scores to evaluate the performance of clinical quality measures and other important aspects of the care and services provided by VHP's network of providers.

1. **Preventive Measures**

   As VHP continues to partner with you on improving member care and related HEDIS measures, we are also encouraging our members to receive their necessary preventive services to keep them healthy. To increase immunizations, our team launched a targeted effort for all members to get their flu vaccine and has also increased access to flu vaccines by expanding its pharmacy network. For more information, please visit **www.valleyhealthplan.org/sites/p/fr/Pages/Pharmacy/Formulary.aspx under > Pharmacy Network Search**.

   VHP's efforts are not enough. We need your assistance to ensure that members are getting their appropriate screenings and preventive services, and we are asking that each of you to reach out to your patients and educate them on the safety and long-term benefits associated with receiving all their immunizations and preventive cancer screenings (i.e., breast, cervical, and colon cancer) on time. Be on the lookout for the upcoming HEDIS education booklet in early January 2021, which will assist you with your billing/procedure coding and other HEDIS focuses.

2. **Maternal Mental Health Program**

   VHP is also focused on increasing maternal mental health screenings during prenatal and postpartum care. The California Legislature enacted Assembly Bill 2193 to raise awareness of the risk factors, signs, and symptoms, as well as treatment options for maternal mental health conditions common with pregnant women and their families. This legislation became effective on July 1, 2019 and requires a licensed health care practitioner, who provides prenatal or postpartum care for a patient, to ensure that the mother is being offered screening and appropriately screened for maternal mental health conditions. Providers serving VHP members can use one of the following screening tools:

   To find the online version of the forms below, please follow the link at **www.valleyhealthplan.org/sites/p/fr/Pages/Resources.aspx**

   - Patient Health Questionnaire-2 (PHQ-2)
   - Patient Health Questionnaire-9 (PHQ-9)
   - Edinburgh Postnatal Depression Scale

   You can refer members with a positive screen to VHP's Case Management Department for further assistance with the member's mental health needs. To make a referral, contact **1.408.885.2600**.

Please see approved claim codes for prenatal and postpartum depression screening encounters in the table below:

Measure ID	Measure Name	Value Set Name	Value Set definition	ICD- 10 codes	CPT
PND	Prenatal Depression Screening and Follow-Up	Behavioral Health Encounter	Major depression, single episode	F32.9	
PND	Prenatal Depression Screening and Follow-Up	Depression Case Management Encounter			99366
PDS	Postpartum Depression Screening	Behavioral Health Encounter	Major depression, single episode	F32.9	
PDS	Postpartum Depression Screening	Depression Case Management Encounter			99366

3. **Follow-Up after hospitalization for mental health issues**
   The VHP team has also focused on ensuring that follow-up and after-care is provided to members who have been hospitalized for a mental health condition. The Quality team is working closely with VHP's Utilization and Case Management teams to reach out to these members to assess and assist to address these members' needs, and to ensure that these members receive their 7-day and 30-day follow-up care appointments. Please monitor your patients' hospitalizations to ensure they receive important follow-up care.
4. **Health Disparity Quality Initiative**
   VHP is committed to reducing health disparities and utilizes racial and ethnic identity information to highlight opportunities for improvements in population health and overall health outcomes. One specific area that we would like you to continue to focus on improving is to increase your engagement and education of VHP members who have failed to achieve the goal of an A1C < 8 and/or have not completed their retinal eye exam as recommended by the US Preventive Task Force. VHP has identified that there is a higher prevalence of diabetic conditions for our Hispanic Covered California members. **www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P**

VHP is committed to improving the care of our members and has identified a barrier to care that may impact each of you. Since the start of the COVID-19 pandemic many patients have not received their necessary routine care and screenings due to the fear of contracting COVID-19. This fear has led to a drop in many patients' access to the face-to-face care they need, either in person or via telehealth. Help us overcome this barrier by proactively reaching out to your members, scheduling preventive appointments, and assuring patients of the protective measures you have instituted to prevent the transmission of COVID-19.

We would like to hear about your successful outreach strategies during this unprecedented time and the

steps you have taken to keep patients safe. Share your experience with us. Reach out to your Provider Relations Representative with your story or send an email to:
ProviderRelations@Vhp.sccgov.org.

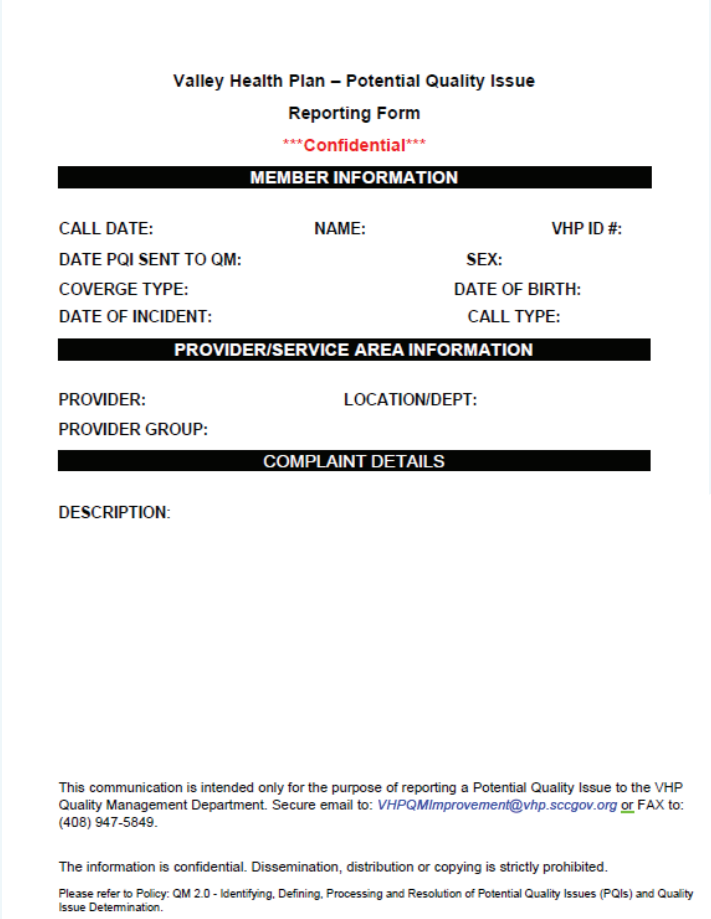
Outreach Strategies to Help Bring Members in for Care:
Below are a few outreach strategies that health care providers can use to maintain engagement with patients.

1) Include messaging and answers to frequently asked questions on your practice's website and phone script. Include this information at the beginning of the recording. Consider adding contact information for hotlines to your website and messages so patients have resources for immediate help if needed – find information at: **www.sccgov.org/sites/phd-p/Diseases/novel-coronavirus/Pages/home.aspx** and **covid19.ca.gov/resources-for-emotional-support-and-well-being**.
2) Send messages to patients using multiple methods of communication, such as:
    - Secure email
    - Secure message through your patient portal
    - Secure text (send all, no reply)
    - Print materials sent via USPS
    - Add important messages to your after hours or hold time phone scripts
    - Promote the use of VHP's telehealth vendor MDLive:
        - Call **1.888.467.4614 (toll-free)**
        - Direct Commercial members here: **www.valleyhealthplan.org/sites/m/pages/mdlive.aspx**
        - Direct Medi-Cal members here: **members.mdlive.com/vhpnetwork/landing_home**
3) Engage office staff and be proactive in reaching out to patients to schedule appointments. Consider having office staff or others on your team make phone calls to offer telephone or video visits to all patients who may have cancelled scheduled appointments.

Potential Quality Incidents
A potential quality incident (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 VHP internal staff. PQIs require prompt attention from practitioners and medical staff. The PQI process is confidential and used by VHP to aid in the evaluation and improvement of the overall quality of care delivered to VHP members.

PQI Form Content

- Type or print legibly and include your complete contact information, including fax number, phone number and email address.
- Summarize a brief description of the events as follows: describe the event (where it occurred, what occurred, who was involved, date and time occurred, etc.).
- Quote relevant statements made by the provider or those involved in the incident.
- Specify any equipment or medication involved.
- Provide a complete explanation describing the potential deviation in the standard of care.
- See PQI Form on the following page:



Valley Health Plan – Potential Quality Issue

Reporting Form

Confidential

MEMBER INFORMATION

CALL DATE: NAME: VHP ID #:

DATE PQI SENT TO QM: SEX:

COVERGE 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.

Providers can complete and submit this form directly via secure email to **VHPQMImprovement@vhp.sccgov**.org or send via fax to: **1.408 947.5849**. The PQI form, found here: **www.valleyhealthplan.org/sites/p/fr/Pages/Resources.aspx**, should be completed within one business day of the event/occurrence. The PQI form is reviewed, investigated, and evaluated by the Quality Management Registered Nurse and a Medical Director. For additional information, refer to the PQI section of VHP's Provider Manual.

Initial Health Assessment for VHP Medi-Cal Members

VHP manages roughly 128,000 Medi-Cal members delegated to VHP by Santa Clara Family Health Plan (SCFHP). The California Department of Health Care Services (DHCS) requires primary care providers to complete an Initial Health Assessment (IHA) for all newly assigned members within 120 calendar days of enrollment. Please make every reasonable effort to complete the IHA within the first 120 days of PCP assignment. Even with you and your office staffs' best efforts, VHP recognizes that conducting the IHA is not always possible. If you have made at least two attempts (one by telephone and one written request) to schedule the IHA and are unsuccessful, please document your attempts in the medical record and submit a claim using both of the new IHA codes (G9604 and Y93.9). G9604 is a HCPCS code used when a patient's survey results are not available. Y93.9 is a billable ICD code used to specify a diagnosis of activity, unspecified. This allows you to report your completed outreach attempts and helps VHP stay compliant with the DHCS policy.

How do you know if a member has been delegated by SCFHP to VHP? Look at the front of your member's SCFHP ID card under the Network section.

FRONT BACK

VHP's Clinical Focus in 2021

- Continue HEDIS education.
- Continue targeted efforts to improve VHP's HEDIS measure rates for women's health (e.g., breast and cervical cancer screening, chlamydia screening, comprehensive diabetes care, controlling high blood pressure, and immunizations).
- Expand reporting to additional network providers to assist in closing gaps in care for VHP members.
- Produce and distribute HEDIS report cards to network providers.
- Continue to implement initiatives to improve quality of care and service as well as to improve member and provider satisfaction.
- Further analyze the Covered California health disparity quality initiative described above.

VHP Pharmacy and Therapeutic Committee: Quarterly Meeting Update

The following formulary decisions and updates apply to VHP's Commercial Employer Group (Employer), Covered California (CoCA) and Individual & Family Plan (IFP).

VHP's Pharmacy & Therapeutics (P&T) Committee meets quarterly to evaluate new prescription products approved by the Food and Drug Administration, changes in drug class, and tier placements. VHP's P&T Committee is comprised of independent physicians and pharmacists.

The following are the strategic clinical decisions made in the September quarterly meeting.

Commercial Employer Group 2 Tier Formulary:
Tier 1 = generic

Tier 2 = Brand CoCA and IFP 5 Tier Formulary:
Tier 0 = birth control, Health Care Reform Act drugs, vaccines

Tier 1 = most generic and low-cost preferred brands

Tier 2 = non-preferred generics, preferred brands

Tier 3 = non-preferred brands

Tier 4 = specialty drugs

Effective Date	Drug Name	Type of Change	Employer Tier	CoCA Tier
10/1/2020	lasmiditan succinate (REYVOW) tab	A, PA, QL	2	4
10/1/2020	rimegepant sulfate (NURTEC) oral disintegrating tab	A, PA, QL	2	4
10/1/2020	cenobamate (XCOPRI) tab	A, PA, QL	2	4
10/1/2020	cenobamate (XCOPRI) pack	A, PA, QL	2	4
10/1/2020	avapritinib (AYVAKIT) tab	A, PA, QL, LD, SF	2	4
10/1/2020	tazemetostat (TAZVERIK) tab	A, PA, QL, LD	2	4
10/1/2020	entrectinib (ROZYLTREK) cap	A, PA, QL, MSP	2	4
10/1/2020	All Formulary Vaccines	Remove Restrictions	0	0

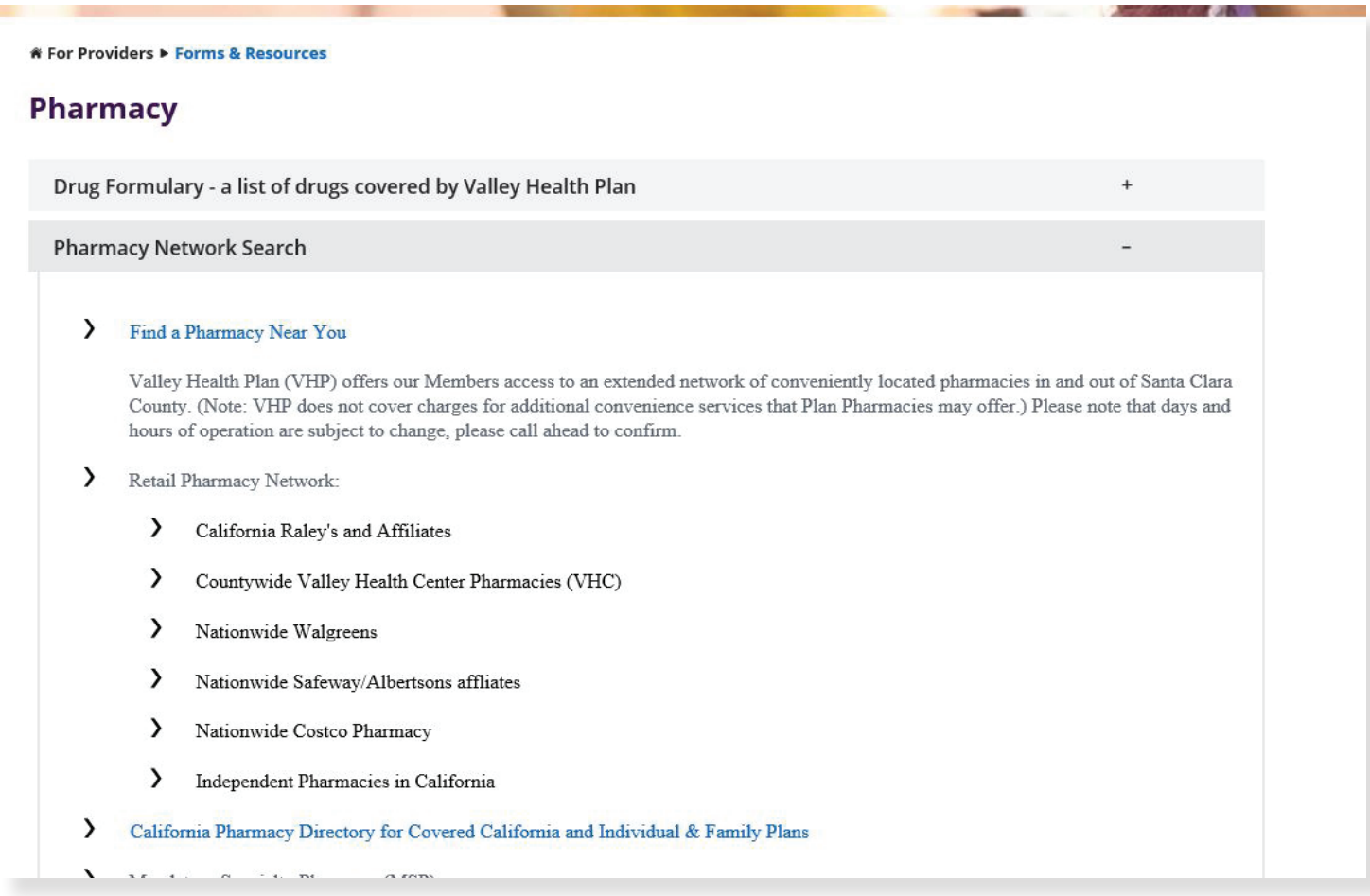
[2]Brand name drugs are displayed in UPPER CASE; generic drugs are displayed in lower case.

Key: A = Add, PA= Prior Authorization, QL = Quantity Limits, MSP = Mandatory Specialty Pharmacy, LD = Limited Distribution, SF = Split Fill

For a complete list of all P&T formulary updates, please visit VHP's website at **www.valleyhealthplan.org/sites/m/pn/Pharm/Pages/Pharmacy.aspx**

VHP Pharmacy List

For a complete list of VHP's pharmacies go here **www.valleyhealthplan.org/sites/p/fr/Pages/Pharmacy/**



Medi-Cal Pharmacy Billing Changes

Background:

The Department of Health Care Services (DHCS) is transitioning Medi-Cal pharmacy services from the Medi-Cal managed care delivery system to the Medi-Cal fee-for-service delivery system Governor Newsom's January 7, 2019 Executive Order N-01-19 is being implemented to achieve cost-savings for drug purchases made by the state, to standardize the pharmacy benefit statewide for all Medi-Cal beneficiaries, and to increase overall access by allowing beneficiaries to receive pharmacy services from a broader fee-for-service pharmacy network. In addition, this standardization is a critical step for the success of the California Advancing and Innovating Medi-Cal (CalAIM) initiatives being proposed by DHCS and Gov. Newsom. For more information on CalAIM, please visit the Department's website at **https://www.dhcs.ca.gov/calaim**.

Magellan will function as the State's Pharmacy Benefits Manager (PBM).

The state identified the advantages of transitioning Medi-Cal pharmacy benefits from Medi-Cal managed care plans to a fee-for-service relationship with Magellan as:

- Standardize the Medi-Cal pharmacy benefit statewide, under one delivery system.
- Improve the access to pharmacy services by giving providers access to a pharmacy network that includes a majority of the state's pharmacies and is generally more expansive than individual Medi-Cal Managed Care Plan pharmacy networks.

- Apply statewide utilization management protocols to all outpatient drugs, as appropriate.
- Strengthen California's ability to negotiate state supplemental drug rebates with drug manufacturers.

As of **April 1, 2021**, Magellan will assume the responsibility from Medi-Cal managed care plans for administering the following when billed by a pharmacy on a pharmacy claim:

- Covered outpatient drugs, including physician administered drugs
- Enteral nutritional products
- Various related medical supplies

Currently, VHP is administering the following covered benefit for our Medi-Cal members under the medical benefit and billed through medical billing:

- Physician administered drugs (PADs)
- Enteral nutritional products

As we move closer to **April 1, 2021,** we will provide further guidance on the implementation of this pharmacy change.

Electronic Data Interchange (EDI) Claims Submission

One impact of the COVID-19 pandemic is that a majority of VHP employees have moved into a remote working environment which has led to a reduction in the number of people available to process of paper claims.

Being mindful of the effect billing paper claims has on our environment, the reduction of on-site staff at VHP, and the improvement on payment processes including turnaround time, VHP encourages all contracted providers to participate in VHP's EDI claims submission program through VHP's EDI clearinghouse, Utah Health Information Network (UHIN). EDI through UHIN allows for a more efficient and cost-effective claims submission process for providers and VHP. The benefits include:

- Faster transaction time (time between submission and payment)
- Reduces overhead and administrative costs, including postage
- Increases accuracy of data and efficient information delivery
- Clearinghouse acknowledges receipt of claims

All the same requirements for paper claims (e.g., timely filing, etc.) apply to EDI claims through UHIN submissions.

Note: Claims not submitted with all the correct data fields may be rejected or denied.

In addition to processing HIPAA-compliant ANSI X12N 837 professional and institutional claims, VHP has the capability to generate an ANSI X12N 835 Electronic Remittance Advice (ERA) and issue payment using Electronic Funds Transfer (EFT).

To submit claims electronically to VHP, all EDI claims must first be forwarded to VHP's clearinghouse. EDI claims should be submitted by the provider's clearinghouse to VHP's clearinghouse at:

Utah Health Information Network (UHIN)

VHP's Trading Partner Number: HT00700-001

Utah Health's Customer Service Number: **1.877.693.3071**

VHP Payer I.D.: VHP01

Soon, VHP will only accept paper claims on an exception basis. If your office is submitting paper claims, please contact your assigned Provider Relations Representative or VHP's Provider Relations Department at **1.408.885.2221** for more information on EDI claims filing.

UHIN can be reached at **uhin.org/solutions/providers/myuhin/**, to streamline your electronic claim submissions process.

Submitting Corrected Claims Electronically

VHP accepts corrected claims electronically. There is no need to submit paper claims for corrected claims. You may submit an electronic corrected claim to VHP using an appropriate resubmission code on the electronic file (837P/I). Please follow these guidelines to submit corrected claims electronically to VHP in the ANSI-837 professional or institutional format.

837P (Professional) Claims

- In Loop 2300 (Claim Information), the CLM segment must have one of these qualifier codes:
  - CLM05-3 – "7" (Replacement); the corrected claim will process as a replacement claim and reverse the original claim on file.
  - CLM05-3 – 8" (Void); the original claim on file will be voided and any previous payments will be recouped.
- The REF*F8 segment must include the original claim number ID, exactly as it appeared in the original claim being corrected—no additional characters.

837I (Institutional) Claims

- In Loop 2300 (Claim Information), the CLM segment must have one of these qualifier codes:
  - CLM05-3 – "xx7" (Replacement); the corrected claim will process as a replacement claim and reverse the original claim on file.
  - CLM05-3 – "xx8" (Void); the original claim on file will be voided and any previous payments will be recouped.
- The REF*F8 segment must include the original claim number ID, exactly as it appeared in the original claim being corrected—no additional characters.

Resubmission Codes – Type of Bill (TOB)

- "xx1"-Original (initial claim)
- "xx7"-Replacement (replacement of prior claim)
- "xx8"-Void (void/cancel of prior claim)

Please remember that you or your billing agent must use one of the above resubmission codes and reference the original claim number on the corrected claim. Corrected claims billed incorrectly will result in claims denials.

If you have any questions about submitting corrected claims, contact VHP's Provider Relations Department at **1.408.885.2221**.

Billing for Late Charges

VHP will not accept separate claims for late charges including but not limited to physicians, free-standing clinics, inpatient or outpatient facility providers. Late charges are services rendered to the patient that were not submitted on the initial claim.

Late charges are indicated on the UB 04 claim form or its electronic alternative (837 I) with bill type (xx5) and HCFA/CMS 1500 or its electronic alternative (837 P) with a resubmission code.

When billing for ancillary, accommodation, diagnosis, or procedure codes for any service that was previously billed and reimbursed, providers must first submit a replacement claim for the original claim. All accurate line items from the original claim submission must appear on the replacement claim along with the line items requiring a correction.

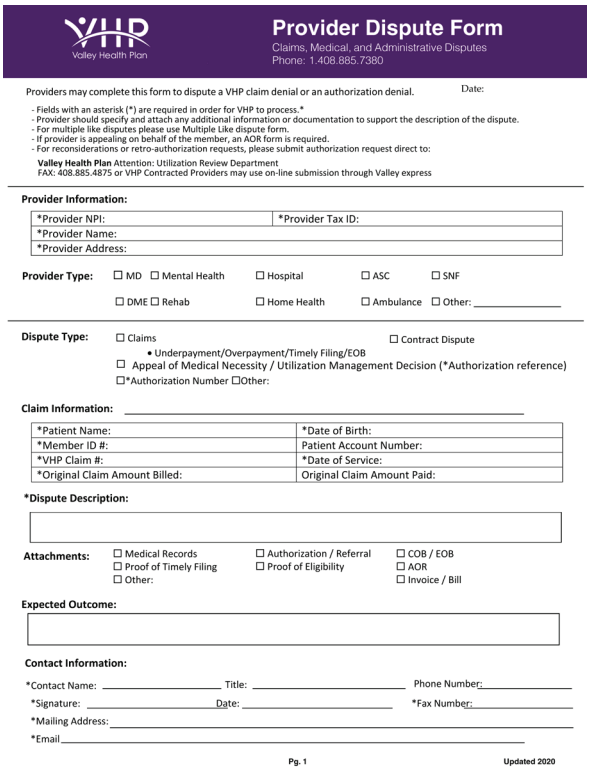
Providers must submit a replacement claim using bill type (xx7) when billing for a replacement facility-based claim or resubmission code (7) for a professional based claim. Late charges billed incorrectly will result in a claim denial.

If you have any questions about billing late charges, please contact VHP's Provider Relations Department at **1.408.885.2221**.

Submitting Provider Disputes

A provider dispute is a written notice to VHP challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered), medical decision(s), or authorization(s) that has/have been denied, adjusted or contested seeking resolution of a billing, authorization, or other contract dispute for redetermination, or disputing a request for reimbursement of an overpayment of a claim. Provider disputes submitted to VHP must include the following data elements. Incomplete disputes or disputes missing any one of the following data elements will be returned to the appellant.

- Appellant contact name
- Appellant email address
- Appellant telephone and fax number
- Date of dispute submission
- Date of service
- Expected outcome
- Member's VHP identification number
- Original claim billed amount
- Patient name
- Provider address
- Provider name
- Provider NPI
- Provider TIN
- Statement of circumstances giving rise to the dispute
- VHP claim number



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:**

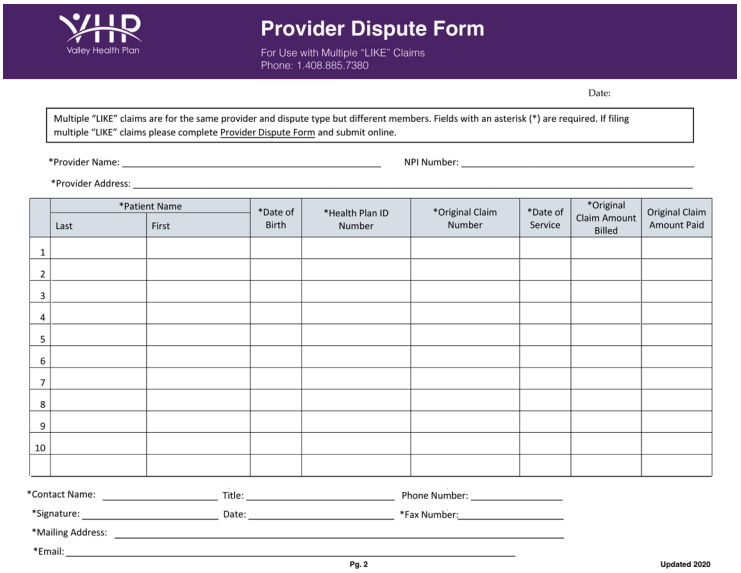
Attachments: ☐ Medical Records ☐ Proof of Timely Filing ☐ Other: ☐ Authorization / Referral ☐ Proof of Eligibility ☐ COB / EOB ☐ AOR ☐ Invoice / Bill

Expected Outcome:

Contact Information:

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

Pg. 1 Updated 2020



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: _____

Pg. 2 Updated 2020

VHP's Provider Dispute Form is located on VHP's website at :**www.valleyhealthplan.org/sites/p/fr/Pages/Resources.aspx**

Disputes should be submitted to:

Valley Health Plan
P.O. Box 28387
San Jose CA 95159

Standing Orientations and Re-Orientations

Your VHP Provider Relations staff has now implemented standing orientations within the first ten business days of every month, excluding holidays. Feel free to join in even if you have already received your initial orientation. We would love to have you join us! Contact your Provider Relations Representative, email **ProviderRelations@vhp.sccgov.org**, or call **1.888.421.8444** to schedule your meeting.

Second Monday Every month Except holidays	Noon to 1:00 PM
Second Tuesday Every month Except holidays	Noon to 1:00 PM
Second Wednesday Every month Except holidays	Noon to 1:00 PM

Second Thursday Every month Except holidays - No orientation on Nov 11, 2021	Noon to 1:00 PM
First Friday Every month Except holidays - No orientation on Jan 1, 2021	Noon to 1:00 PM

VHP Wants Members & Providers Know - We Speak their Language!

To continue to provide high-quality language services, VHP has changed the language services telephone number. To access language assistance, call **1.844.670.6820 (toll-free)**; services are available 24/7. There is no need to ask family or friends to interpret for members. ***Providers and members can request interpreter services at no cost.***

Notification of New Commercial Provider Manual

VHP recently updated the VHP Provider Manual for Commercial, Covered California and Individual & Family Plans.

On November 24, 2020, VHP sent out this letter to all participating providers:

Valley Health Plan (VHP) is excited to release its 2021 Provider Manual, which is effective February 1, 2021 for VHP's Commercial Employer Group (Classic and Preferred), Covered California and Individual & Family Plan. The 2021 Provider Manual is currently on VHP's website at **www.valleyhealthplan.org/sites/p/fr/Pages/Forms-and-Resources.aspx > under Provider Manual**

For those providers contracted to serve VHP's Medi-Cal members, please continue to reference VHP's 2020 Provider Manual available on VHP's website at www.valleyhealthplan.org under the Provider Manual section. VHP's new Medi-Cal Provider Manual will be released in Q1 2021.

VHP's Provider Manual has been redesigned based on feedback provided by VHP's community of providers, enhanced to assist you in responding to questions from VHP's members, includes a Quick Reference Guide (QRG) that contains VHP resource information, and speaks to VHP's policies, procedures, operating practices, and provider-related regulatory requirements.

We value your commitment to the health and well-being of our communities, to the quality of health care services you provide in those communities, and we thank you for being a member of the VHP provider community. To receive a printed copy of VHP's 2021 Provider Manual and a laminated copy of the QRG, or to provide recommendations for future improvements to VHP's Provider Manual, please contact your assigned Provider Relations Specialist or you can call the Provider Relations main line at **1.888.421.8444**.

Written questions or comments can be submitted to:

Valley Health Plan
c/o Provider Operations Administration – Provider Manual
2480 N. First Street, Suite 160
San Jose, CA 95131

To contact your Provider Relations Representative or to request a printed copy, please email **ProviderRelations@vhp.sccgov.org** or you can obtain an electronic version from our website located here: **www.valleyhealthplan.org/sites/p/fr/Pages/Forms-and-Resources.aspx > under Provider Manual**

VHP Non-Delegated Quick Reference Guide (QRG)

VHP has created an easy to use QRG for your convenience. The QRG provides a list of contact information for key departments, addresses, a link to the VHP website, and a list of VHP holidays. Please reach out to your Provider Relations Representative or email **ProviderRelations@vhp.sccgov.org** to order a laminated QRG.

Improving Provider Data Management with the Symphony Provider Directory

VHP is excited to announce its participation in IHA's Symphony Provider Directory. As the statewide platform for provider data management, the Symphony Provider Directory streamlines the way health plans and providers exchange and reconcile provider information in compliance with state and federal regulatory requirements. Stakeholders across California are collaborating to improve the quality of provider information in member directories so that consumers can make more informed decisions about their coverage and care. We are encouraging our provider groups to join us in working with Symphony Provider Directory so we can simplify the way we exchange information.

What is the Symphony Provider Directory?

The Symphony Provider Directory is a cloud-based technology that streamlines the wayhealth plans and providers exchange and reconcile provider information in compliance with state and federal regulatory requirements.

How does Symphony help providers?

The Symphony Provider Directory:

- Enables providers to formally attest for all participating health plans in one place thereby lessening the burden on providers to validate information submitted to each health plan.
- Supports compliance with regulatory requirements.
- Leverages primary sources to automate verification.
- Increases data quality and accuracy.
- Improves the health plan's ability to communicate with providers by cross-checking contact information.
- Reduces labor-intensive and manual roster management by automating the data-exchange process.

To learn more about the Symphony Provider Directory, visit **www.symphony.iha.org** or email **symphonyinfo@iha.org**.

VHP Member Rights and Responsibilities

VHP members have the following rights and responsibilities, which are published on an annual basis in the member's Evidence of Coverage (EOC) and in VHP's Provider Manual, both of which are available on the VHP website at **www.valleyhealthplan.org** or by contacting the Member Services Department at **1.888.421.8444**.

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 dignity, respect, and consideration;
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;
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 refusal, unless medically inadvisable;
13. Readily accessible and ready referral to Medically Necessary Covered Services;
14. A second medical opinion, when medically appropriate, from a Plan Physician within the VHP Network;
15. Be able to schedule appointments in a timely manner;
16. Reasonable continuity of care and advance knowledge of the time and location of your appointment(s);

17. Reasonable responses to any reasonable requests for Covered Services;
18. 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;
19. Change your Primary Care Physician;
20. Review your medical records, unless medically inadvisable;
21. Be informed of any charges (Co-payments) associated with Covered Services;
22. 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;
23. Leave a Plan Facility or Hospital, even against the advice of Plan Providers;
24. Be informed of continuing health care requirements following your discharge from Plan Facilities or Hospitals;
25. Be informed of, and if necessary, given assistance in making a medical Advance Directive;
26. Have rights extended to any person who legally may make decisions regarding medical care on your behalf;
27. Know when Plan Providers are no longer under a contractual arrangement with VHP;
28. Examine and receive an explanation of any bill(s) for non-Covered Services, regardless of the source(s) of payment;
29. File a Grievance without discrimination through VHP or appropriate State or federal agencies;
30. Know the rules and policies that apply to your conduct as a Member.

A Member has the responsibility to:

1. Adhere to behavior that is reasonably supportive of therapeutic goals and professional supervision as specified;
2. Behave in a manner that doesn't interfere with your Plan Provider or their ability to provide care;
3. Safeguard the confidentiality of your own personal health care as well as that of other Members;
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 Emergency Services or is authorized);
5. Cooperate with VHP or a Plan Provider's third-party recovery efforts or Coordination of Benefits;
6. Participate in your health care by scheduling and keeping appointments with Plan Providers. If you cannot keep your appointment, call in advance to cancel and reschedule;
7. Report any changes in your name, address, telephone number, or your family's status to your employer and a VHP Member Services Representative.

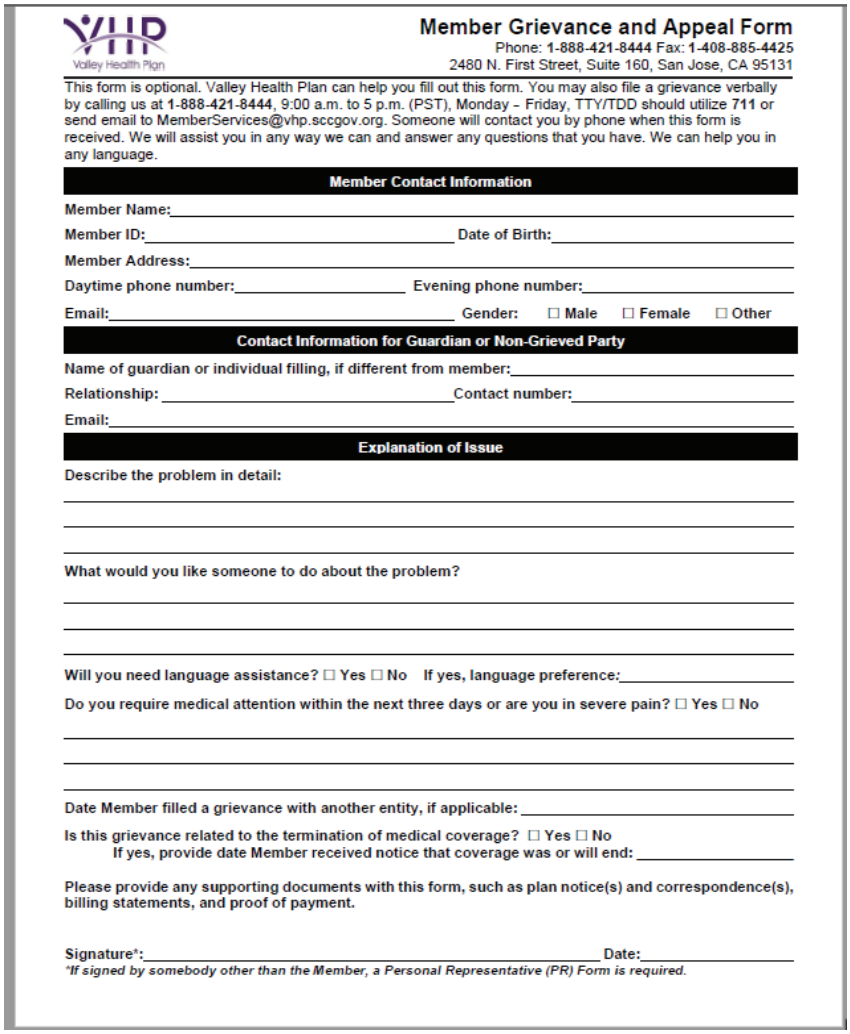
Provider Representation for Member Grievances and Appeals

With written consent, a provider may file a grievance or appeal on behalf of a member. To act as the member's representative, the member and provider complete the Personal Representative Form (PRF) and submit the completed PRF along with the grievance or appeal. Grievances may be submitted by either calling the Member Services Department or submitting the grievance form in writing. A grievance or appeal may be filed with VHP by one of the below methods:

1. Contact VHP's Service Operations Department at **1.888.421.8444 (toll-free)**.
2. Submit an online grievance form in English, Spanish or Vietnamese through VHP's website **www.valleyhealthplan.org/sites/m/mm/Grievances/Pages/GrievanceForm.aspx**.
3. Mail the grievance for to:
   VHP's Service Operations Department
   2480 N. First Street, Suite 180,
   San Jose, CA 95131.

Providers are required to fully cooperate with VHP staff when contacted about a grievance investigation.

The Grievance and Appeal form is located on the VHP website at: **www.valleyhealthplan.org/sites/p/fr/Pages/Resources.aspx**



Valley Health Plan

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.*

Medi-Cal Providers: How to Bill for Blood Lead Screening

Did you know?

California Health & Safety Code Sections 124125 to 124165 (**https://bit.ly/HSC-leadtest**) declared childhood lead exposure as the most significant childhood environmental health problem in the state and established the Childhood Lead Poisoning Prevention Program to reduce the incidence of childhood lead exposure in California. Learn more about the issue at **https://bit.ly/childhood-lead**.

Why is it important?

Lead in blood has been shown to negatively affect IQ, ability to pay attention, and academic achievement. Santa Clara Family Health Plan (SCFHP) encourages providers to perform periodic health assessments on children between the ages six (6) months and six (6) years. California regulations require a blood lead test at ages 12 months and 24 months (California Department of Public Health, 2018).

How to bill for lead level screening

CPT	Description
83655	Blood lead test
36416	Capillary collection

Anticipatory Guidance	At each periodic assessment from six (6) months to six (6) years, all health care providers are required[1] to inform parents and guardians about: • The risks and effects of childhood lead exposure • The requirement that children enrolled in Medi-Cal receive blood lead tests • The requirement that children not enrolled in Medi-Cal who are at high risk of lead exposure receive blood lead tests
Blood Lead Test	• For all children in publicly supported programs such as Medi-Cal, Women, Infants and Children (WIC), and CHPD at both 12 months and 24 months of age[1] • Perform a "catch up" test for children ages 24 months to six (6) years in a publicly supported program who were not tested at 12 and 24 months
Assess	• If child is not in a publicly supported program, do the following: o Ask your patient, "does your child live in, or spend a lot of time in, a place built before 1978 that has peeling or chipped paint or that has been recently remodeled?" o If they anwer "yes" or "don't know", require blood lead test • Require blood lead test if a change in circumstances has put child at risk of lead exposure • Other indications for a blood lead test (not in regulation but should be considered): o Parental request o Sibling, playmate, or other close contact with an increased blood lead level o Suspected lead exposure o History of living in or visiting country with high levels of environmental lead

[1] Health and Safety Code, sections 105285-105286; California Code of Regulations, Title 17, Sections 37000 to 37100. Source: California Department of Public Health, 2018

Resources

California's Childhood Lead Poisoning Prevention Program: **bit.ly/childhood-lead**

DHCS's blood lead test and anticipatory guidance: **bit.ly/DHCS-lead-guidance**

Changes to Mid-Level Provider Billing with VHP

Beginning on August 1, 2020, VHP began allowing for qualifying mid-level practitioners to begin billing for services rendered independent of a supervising physician using their own individual National Provider Identifier (NPI). These guidelines are set forth by the Centers for Medicare and Medicaid Services (CMS) for the Commercial lines of business (LOB) and by the DHCS for the Medi-Cal.

To be considered as a qualifying mid-level practitioner for direct billing with VHP, you must have your own NPI, be credentialed with VHP in the specialty in which you plan to practice, and participate with a physician group contracted with VHP.

VHP has updated its payment practices and included the revisions in the table below. Areas highlighted in "Yellow" are additions to the previous communication and areas with ~~"Red strike-through"~~ font are deletions.

Category	Commercial – LOB	Medi-Cal Managed Care – LOB
Reference	• CMS Guideline entitled "Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants – April 2020"	• DHCS All Plan Letter (APL) 18-022 • DHCS Provider Manual section on Non-Physician Medical Providers
Qualifying Practitioners	• Certified Registered Nurse Anesthetists (CRNA) • Nurse Practitioners (NP) • Certified Nurse Midwives (CNM) • Clinical Nurse Specialists (CNS) • Physician Assistants (PA)	• Certified Registered Nurse Anesthetists (CRNA) • ~~Physician Assistants (PA)~~ • ~~Nurse Practitioners (NP)~~ • Certified Nurse Practitioners (CNP) • Certified Nurse Midwives (CNM) • Licensed Midwives (LM)
Reimbursement	• CRNAs, NPs, CNMs, CNSs, and PAs will be reimbursed according to Medicare Guidelines in accordance with the current contract. • ~~PAs, NPs, and CNSs, will be reimbursed at 85% of the established rate paid to physicians providing the same service in accordance with the current contract.~~	• CRNAs, ~~PAs, NPs,~~ CNP and CNMs will be reimbursed at 100% of the established rate paid to physicians providing the same service in accordance with the current contract. • CNMs acting as an "assistant at surgery" will be reimbursed at 85% of the established rate paid to physicians providing the same service in accordance with the current contract for Cesarean Sections only. • LMs will be reimbursed at 100% of the contracted rate for services within their scope of practice as non-physician licensed Practitioners.

Category	Commercial – LOB	Medi-Cal Managed Care – LOB
Provider Requirements	CRNAs must: 1. Be under the general supervision of a physician certified by the Medical Board of California. 2. Be licensed as a registered nurse by the California Board of Registered Nursing. 3. Meet licensure requirements the State imposes on non-physician anesthetists. 4. Have graduated from a nurse anesthesia educational program that meets the standards of the Council on Accreditation of Nurse Anesthesia Educational Programs (COA) 5. Have passed a certification examination from the National Board of Certification and Recertification for Nurse Anesthetists NPs must: 1. Be under the general supervision of a physician certified by the Medical Board of California. 2. Be licensed by the California Board of Registered Nursing or NPs. 3. Be certified as an NP. CNMs must: 1. Be licensed as a registered nurse by the California Board of Registered Nursing. 2. Be certified to practice nurse-midwifery.	CRNAs must: 1. Be enrolled as an independent provider in the Medi-Cal program. 2. Be under the general supervision of a physician certified by the Medical Board of California. 3. Be licensed as a registered nurse by the California Board of Registered Nursing. 4. Meet licensure requirements the State imposes on non-physician anesthetists. 5. Have graduated from a nurse anesthesia educational program that meets the standards of the Council on Accreditation of Nurse Anesthesia Educational Programs (COA) 6. Have passed a certification examination from the National Board of Certification and Recertification for Nurse Anesthetists CNPs must: 1. Be enrolled as an independent provider in the Medi-Cal program. 2. Be licensed as a nurse and certified as a nurse practitioner by the California Board of Registered Nursing. 3. Be nationally board certified.

Category	Commercial – LOB	Medi-Cal Managed Care – LOB
Provider Requirements	CNSs must: 1. Be under the general supervision of a physician certified by the Medical Board of California. 2. Be licensed as a registered nurse by the California Board of Registered Nursing. 3. Have a Master's degree in a defined clinical area of nursing from an accredited educational institution. 4. Be certified as a CNS by a national certifying body. PAs must: 1. Be licensed with the California Physician Assistant Board. 2. Have graduated from a PA educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant. 3. Certified by the National Commission on Certification of Physician Assistants.	CNMs must: 1. Be licensed as a registered nurse by the California Board of Registered Nursing. 2. Be certified to practice nurse-midwifery. LMs must: 1. Be licensed to practice midwifery by the Medical Board of California. ~~PAs must:~~ 1. ~~Be under the general supervision of a physician certified by the Medical Board of California.~~ 2. ~~Be licensed by the Medical Board of California PAs.~~ ~~NPs must:~~ 1. ~~Be under the general supervision of a physician certified by the Medical Board of California.~~ 2. ~~Be licensed by the California Board of Registered Nursing or NPs.~~ 3. ~~Be certified as an NP.~~
Billing Requirements	Qualifying mid-level practitioners must: 1. Be credentialed with VHP for the scope of practice for which they are billing. 2. Have their own NPI. 3. Bill under a contracted provider organization TIN and NPI	Qualifying mid-level practitioners must: 1. Be credentialed with VHP for the scope of practice for which they are billing. 2. Have their own NPI. 3. Bill under a contracted provider organization TIN and NPI.

We want to hear from you! Share with us!

Do you have a patient success story,

A favorite recipe,

A health care related joke, pun, or comic strip,

An idea on how to improve the patient/doctor relationship, or

An idea or thought another provider may benefit from hearing,

We want to give you a chance to engage your fellow VHP providers, so if you have an idea, a topic, or an experience you would like to share; please submit a written summary here: **ProviderRelations@vhp.sccgov.org**, and it will be reviewed for inclusion and timing. If your submission is selected, a representative from VHP will contact you directly.

VHP CHIEF EXECUTIVE OFFICER
Laura E. Rosas, JD, MPH

VHP CHIEF MEDICAL OFFICER
Ghislaine Guez, MD

VHP CHIEF OPERATIONS OFFICER
Debra Halladay

VHP CHIEF FINANCIAL OFFICER
Paul Antigua

VHP CHIEF BUSINESS DEVELOPMENT OFFICER
Ruth Liu

VHP ASSISTANT DIRECTOR, PROVIDER NETWORK OPERATIONS
Justin Keller

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Valley Health Plan is located at:
2480 N. First Street, Suite 160
San José, CA 95131

1.888.421.8444 (toll-free)

www.valleyhealthplan.org