



VALLEY HEALTH PLAN

# Provider Manual 2020





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## Introduction

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The Provider Manual is intended for Network Providers in Valley Health Plan (VHP). The Provider Manual contains policies and procedures that describe how to submit claims and encounter data, to obtain authorizations and referrals, and to understand covered services. All Network Providers should use this Manual as the primary reference for the policies and guidelines of Valley Health Plan.

### Section 1:

This Manual contains policies, procedures and guidelines for Valley Health Plan's product lines:

- Valley Health Plan Commercial
- Santa Clara Family Health Plan–Network 2
  - Medi-Cal Managed Care
  - Healthy Families
  - Healthy Kids

The VHP Provider Manual is divided into the 16 sections:

Section 1:	Introduction
Section 2:	Authorization & Referrals
Section 3:	Claims
Section 4:	Summary of Benefits
Section 5:	Primary Care
Section 6:	Ancillary Services for Chiropractic and Acupuncture
Section 7:	Mental Health and Substance Abuse
Section 8:	Urgent and Emergency Care
Section 9:	Case Management
Section 10:	Pharmacy
Section 11:	Health Education
Section 12:	Provider Relations (Including Dispute Process)
Section 13:	Quality Management
Section 14:	HIPAA
Section 15:	Forms and Attachments
Section 16:	Glossary of Terms

You can access the Provider Manual at our website: [www.valleyhealthplan.org](http://www.valleyhealthplan.org) or for a hard copy please contact the Provider Relations Department at (408) 885-2221.

This Manual provides a summary of the important features of Valley Health Plan. The Member Handbook, Evidence of Coverage and the Summary of Benefits for each product line contain more detailed information on the exact terms and conditions of VHP coverage and on the benefits, limitations and exclusions.

**Our Mission**

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

**Our Goal**

To support the well-being of our members through a commitment to accessible, high-quality health services and community-focused, local care.

**Background**

Valley Health Plan, an HMO that is owned and operated by Santa Clara County, is licensed by Knox Keene and has offered healthcare insurance to County employees since 1985. Valley Health Plan offers four distinct products. The Commercial product is available to County Employees and their dependents and selected other non-profit and Santa Clara County related organizations. The Delegated product includes Managed Medi-Cal, Healthy Families and Healthy Kids. Santa Clara Family Health Plan (SCFHP) is the plan of record for these products and is responsible for the Membership. SCFHP delegates to Valley Health Plan the responsibility to provide all covered services except Mental Health, Dental, and Vision Care to assigned SCFHP Members.

**Valley Health Plan Network**

VHP operates as an integrated network that provides a comprehensive range of hospital, physician and other health care services for its Members.

The Valley Health Plan Network includes:

- Santa Clara Valley Medical Center (hospital, practitioners and affiliated health centers)
- Lucile Packard Children's Hospital and practitioners
- Stanford Medical Center and practitioners
- O'Connor Hospital
- Saint Louise Regional Hospital
- El Camino Hospital
- Community Clinics (Mayview Community Health Centers, Planned Parenthood Mar Monte, Gardner Family Health Network, East Valley Community Clinic, Indian Health Center of SCC, School Health Clinics of SCC, North East Medical Services, San Jose Foothill Health Centers, and Asian American Community Involvement).
- Several Independently contracted primary care physicians
- Santa Clara County Independent Physician Association (SCCIPA physicians)
- San Jose Medical Group (SJMG)
- Palo Alto Medical Foundation (PAMF)
- Northern Cal Advantage Medical Group
- California IPA

## Valley Health Plan Contacts

Valley Health Plan is available to respond quickly to your questions and concerns.

Office hours are Monday through Friday, 8:00 a.m. to 5:00 p.m.

<b>Claims Department</b> Responsible for processing of all claims including electronic claims (EDI). Claims Department is able to provide status on claims received.	(408) 885-4563
<b>Utilization Management (UM) Department</b> Reviews and authorizes referrals to facilities and services. UM Department can provide status on authorizations and referrals.	(408) 885-4647 Fax (408) 885-4875
<b>Health Education</b> Offers Member education on access to care; use of preventive services and health maintenance and improvement.	(408) 885-3490 Fax (408) 954-1023
<b>Provider Relations Department</b> Educate providers about VHP policies and procedures. Provider Relations offers training in all aspects of provider interactions with VHP.	(408) 885-2221 Fax (408) 943-5277
<b>Medical Director/Associate Medical Directors</b> Manages and directs all clinical issues, including final determination of all authorizations.	(408) 885-5924
<b>Member Services Department</b> Assists Members in resolving service issues, questions pertaining to coverage, benefits, and assists in selecting a Primary Care Physician.	(408) 885-4760 Fax (408) 885-4425
<b>Quality Management Department</b> Assesses the quality of all services delivered to plan Members.	(408) 885-5924 Fax (408) 885-3590
<b>Language Assistance</b> – Valley Health Plan Providers can access telephone language translation assistance for VHP Members. In order to access Language Services the provider will be required to enter a system password. To obtain the password contact Provider Relations at (408) 885-2221.	(408) 278-9927
<b>VHP Administration</b>	(408) 885-5780 Fax (408) 885-5921

VHP observes the following holidays:

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

The following is sampling of services which require authorization. For a detailed list, please refer to the Authorization Guidelines or on-line at [www.valleyhealthplan.org](http://www.valleyhealthplan.org) in For Providers.

- Acupuncture and Chiropractic services
- Mental Health Services for Psychiatrists
- Durable Medical Equipment
- Formulas & other Enteral Therapy
- Hemodialysis & Peritoneal Dialysis
- Home Health Care
- Hospice
- In-patient services
- Non-emergent medical transportation
- Non-formulary prescription drugs
- Outpatient Services including diagnostic and laboratory service
- Prosthetics and Orthotics
- Rehabilitation therapy services
- Skilled Nursing Care
- Specialty Services

VHP will authorize an initial visit and up to 3 follow up visits with a specialist. The specialist may request additional visits by requesting an authorization and submitting a plan of care. The specialist must submit regular reports to the PCP.

VHP may establish standing referrals to a specialist for a Member who has a chronic, life threatening or disabling condition such as cancer or end stage kidney, liver or heart disease, or HIV/AIDS. A specialist coordinates care over a long period of time. The Member may still seek care from the PCP for problems unrelated to the specified condition.

**Authorization Procedures**

To obtain an authorization on-line, please go to our on-line system, Valley Express; for more information please contact Provider Relations. If you do not have access to the on-line system, and you wish to obtain access, please call Provider Relations at 408 885-2221, or complete and submit the “Referral” or “Treatment Authorization Request”(TAR) form (see Section 14 Forms & Attachments) Clearly identify the service requested and the medical justification for this service. The following information is required on the TAR:

- Diagnosis (ICD-9)
- Service Requested (CPT-4)
- Number of visits requested
- Reason the service is medically necessary, including documentation such as H&P and progress notes
- Name of rendering provider requested
- Name of referral provider submitting the request
- Name of Member and Member’s VHP ID number

If the “Treatment Authorization Request” is not fully completed, the UM staff will request the needed information. If the additional information is not provided within 10 working days, the

request will be closed. If the request has been closed, a new TAR must be submitted to UM prior to performing services.

### **Routine and Urgent Authorization Requests**

VHP will process routine authorizations within five (5) business working days and urgent authorizations in 72 hours. A Member or Provider who feels that life or quality of life is in jeopardy if the normal authorization processing time is followed may request an expedited review that must be completed within 24 hours.

### **Self-Referral Services**

Commercial Members may arrange for obstetric-gynecological (OB/GYN) services and for Sensitive Services with VHP Network Providers.

Commercial Members can contact the Dermatology Department at Santa Clara Valley Medical Center directly and do not need a referral or authorization. For Mental Health, Members may self refer to a Licensed Clinical Social Worker, Marriage Family Therapist or Psychologist in the VHP Mental Health Network. Network Mental Health providers will need to call VHP to confirm Member eligibility.

Santa Clara Family Health Plan Members may self-refer to OB/GYN services, acupuncture and chiropractic services within the Valley Health Plan Network. Mental health services are provided to SCFHP Members through the County Mental Health Center; please contact SCFHP for more information. There is no referral needed for HIV testing or family planning.

### **Emergency Services**

Emergency services do not require prior authorization, however admission to any hospital other than Santa Clara Valley Medical Center after a Member has been stabilized, does require authorization.

UM Department staff will process an Emergency TAR immediately.

Emergency services will be reviewed on a retrospective basis, if necessary, to determine medical necessity as defined above.

### **Guidelines for Referrals to Specialists**

The primary care physician (PCP) coordinates all specialty care or other covered services.

Before the Member receives specialty services, their PCP must refer them. Certain self-referral care as listed on Page 1-6 are exceptions.

The Member's PCP requests services for the Member from one of VHP's Network specialists. For a current list of specialty providers, please contact VHP's Provider Relations Department at (408) 885-2221 or refer to Valley Express on-line authorization system.

If your group or network refers Specialty services to SCVMC, appointments are arranged through the SCVMC Referral Center. Should it be necessary for a Member to receive specialty services outside of your provider group, the PCP must submit a written request to VHP. Please check whether or not your group requires an authorization for specialty services. When all necessary referral information is provided, VHP will inform the Member and the physician of its decision within five (5) business days.

PCPs should discuss the specialty visit with the Member and provide any special instructions.

If a Member has a serious chronic condition that may require a standing referral, the PCP will contact the VHP specialist and discuss the coordination of the Member's care. In most cases VHP must pre- authorize a standing



referral depending on your group or network. The PCP is responsible for requesting and coordinating these services to ensure continuity of care. Member will be advised of the decision by VHP within five (5) business days.

#### **Authorization Review Process**

VHP reviews authorizations to certify that a proposed treatment, procedure, or hospitalization is medically necessary and appropriate. VHP reviews requests for:

- a) Determination of benefit coverage
- b) Medical Necessity
- c) Early identification for discharge planning

#### **Authorization Decision Process - Medical Necessity Criteria**

Clinical review criteria are based on professionally and nationally recognized standards of practice that are developed and adopted by the UM Department. The following criteria is used by the UM staff to review authorization requests for all types of medical services.

- 1. Clinical Practice Referral Guidelines
- 2. Mandated benefits – Medi-Cal and Medicare
- 3. Apollo Medical Criterion
- 4. McKesson InterQual Criteria
- 5. Milliman Care Guidelines

If medical review criteria are met, UM will authorize services and issue an authorization letter to the Member, referring provider and rendering provider. All treatment authorization requests are monitored for the following criteria:

- a) Member eligibility
- b) Determination of benefit coverage
- c) Provider status (in network or out of network)
- d) Coverage by other payers
- e) History of medical condition and prior treatments
- f) Urgency of clinical condition
- g) Medical necessity

The VHP Medical Director makes all denials when a medical review criterion is not met. Services may be denied for the following reasons:

- a) Member ineligible
- b) Not a covered benefit
- c) No Treatment Request or prescription
- d) No prior authorization
- e) Exhausted benefit/benefit exceeded
- f) Services available in network
- g) Inappropriate setting
- h) Not medically necessary

### **Disclosure of Utilization Management Criteria**

Providers may request a written copy of UM Policies and Procedures and/or UM Medical Necessity Criteria utilized in the decision-making process. Please contact Provider Relations Department for a copy of the UM criteria or guidelines.

### **Dispute Authorization Denial**

If a TAR is denied, a Provider may request reconsideration of denied services in writing through the Provider Dispute process. Please contact Provider Relations at (408) 885-2221 to dispute a denial.

### **Affirmative Statement About Financial Incentives**

Valley Health Plan affirms that:

1. Utilization Management (UM) decision making is based only on appropriateness of care and service and existence of coverage.
2. The Plan does not specifically reward practitioners or other individuals for issuing denials of coverage.
3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

### **DMHC Grievance**

The Member also has the right to submit a request for an expedited grievance to the Department of Managed Health Care (DMHC). 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 the health. This includes, but is not limited to, severe pain or potential loss of life, limb, or major bodily function. The DMHC will resolve an expedited grievance within 72 hours and DMHC can contact VHP 24 hours a day, 7 days a week.

**TIPS FOR TIMELY PAYMENT**

- Complete all required information on UB 04 or CMS 1500
- Check for accuracy
- Double check CPT/ICD9 Codes
- Section 3: • Avoid duplicate billing
- Include TID or SSN as appropriate
- Include NPI # for facility and rendering practitioner

**Claims Submission**

The Claims Department is primarily responsible to ensure accurate and timely processing of claims and encounter data.

All paper claims for covered services provided to eligible Members must be submitted on CMS 1500 Form (for all professional services, durable medical equipment (DME) and supplies and Laboratory Services) or on UB 04 Form (for all institutional facility charges inpatient/outpatient). All claim forms and claim-related documents, including “Claim Inquiry Forms” (CIFs) and disputes, must be signed and dated by the provider or a designee.

Claims must be sent to the appropriate address listed below.

VHP Commercial  
P.O. Box 26160  
San Jose, CA 95159

VHP Medi-Cal  
P.O. Box 28407  
San Jose, CA 95159

VHP Healthy Families/Healthy Kids  
P.O. Box 28410  
San Jose, CA 95159

VHP must receive claims and encounter data from contracted providers within ninety (90) days from the date of service. VHP has 45 working days from the date of receipt to reimburse, contest, or deny a claim.

Instructions for completing claim forms can be found in the Medi-Cal/EDS Provider Manual, Section 300. In compliance with HIPAA regulations, information must be typed. Incomplete or illegible claims will be denied, rejected and/or returned to the provider unprocessed. To ensure timely processing, claims must include the following information:

- a) Member's full name and address
- b) Member's VHP identification number
- c) Member's date of birth
- d) Member's gender
- e) Member's managed care plan affiliation
- f) Diagnosis code (ICD-9) and description
- g) Procedure code (CPT, HCPCS)
- h) Appropriate and/or required Modifiers
- i) Billed amount
- j) Date of service
- k) Place of service
- l) Physician's name (not name of physician group) and license number
- m) Physician's address and telephone number
- n) Physician's Tax Identification Number and National Practitioner Identification number (NPI)
- o) Physician's, supplier's Billing Name, Address and Phone number when applicable

- p) Medi-Cal Provider Number (For Medi-Cal claims)
- q) Other insurance information, when applicable

### **Coding Claims**

Claim forms must be coded appropriately according to state and federal regulations using the following:

- a) CPT codes - the Physicians Current Procedural Technology Manual published by the American Medical Association.
- b) HCPCS codes - the Common Procedure Coding System published by CMS.
- c) ICD-9-CM codes - the ICD-9-CM Code Book for Physician Payment, published by St. Anthony Publishing.
- d) Medi-Cal Managed Care codes - the Medi-Cal/EDS Provider Manual.
- e) Medi-Cal modifier codes must be used when appropriate and are in the Medi-Cal/EDS Provider Manual.

### **Child Health and Disability Prevention Program (CHDP)**

All CHDP claims must be submitted on PM-160 claim form and are only reimbursable for Medi-Cal Members. Please submit all CHDP claims to the appropriate Valley Health Plan post office box. To ensure timely processing of CHDP claims, claims must include the following:

- a) Member's full name and address
- b) Member's VHP Identification number
- c) Member's date of birth
- d) Member's gender
- e) Patient's county of residence
- f) County Code
- g) Next CHDP Exam
- h) Ethnic Code
- i) Date of Service
- j) Appropriate Fees
- k) ICD-9 Codes
- l) Physician's name, license number and Tax Identification Number
- m) National Practitioner Identification number (NPI)

### **Claims for Sterilization and Hysterectomy Procedures**

All Medi-Cal Managed Care claims submitted for sterilization and hysterectomy procedures must have a copy of the completed and signed sterilization consent form, PM330, attached to the claim. If the claim is submitted without the PM330 form, the claims will be denied, rejected and/or returned to the provider unprocessed. Claim billing instructions can be found in the Medi-Cal/EDS Provider Manual, please visit their website: [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)

### **California Children Services (CCS) Claims**

All claims for services related to a CCS-eligible condition must first be submitted to California Children Services. Claims submitted to VHP must include the denial letter from CCS or the claim will be denied.

### **Electronic Claims Submission Using EDI**

The electronic claims submission process is a more expedient and efficient way to process claims. In general, the claims submission requirements for electronic billing are the same as for paper claims and are subject to the same claim edits and audits. Electronic claims bypass the claims preparation and data entry processes and goes directly into

claims system for adjudication, which significantly reduces processing time. To initiate electronic billing, contact the VHP Provider Relations Department at (408) 885-2221.

**Retrospective Claims Review**

Providers will be contacted and alerted to any uncommon billing patterns or trends that may delay processing of claims. To avoid second handling of claims, VHP Claims staff reviews and analyzes claim reports and seek opportunities for the overall improvement of a provider's claims submission process. If necessary, a Provider Relations representative will meet with the provider's billing representative to educate and update them regarding the appropriate billing policies and procedures.

**Non-Covered Claims**

For Medi-Cal Managed Care, claims for non-covered services must be routed to Medi-Cal/EDS or the appropriate federal or state agency. If a Medi-Cal Managed Care or a VHP Commercial claim for a non-covered service is submitted to VHP, the claim will be denied.

**Billing Time Limits**

Contracted providers have 90 days from the date of service to submit a claim for payment. An exception to the billing time limit will be allowed if the reason for late billing is one of the approved reasons as defined in the table below:

**Valley Health Plan Billing Time Limit Exceptions**

Code	Code Description	Time Limit	Procedure
1	Medicare	Claims must be received by VHP no later than 12 months after the month of service.	Submit a copy of Medicare's "Explanation of Member Benefits" (EOMB) or the denial letter from Medicare with the claim.
2	Other Coverage (O/C), including all other health insurance carriers and PHPs/HMOs/PPOs	Claims related to these circumstances must be received by VHP no later than 12 months after the month of service	Submit a copy of the "Explanation of Benefits," Remittance Advice report or the denial letter from the O/C with claim.

**Remittance Advice (RA)**

Providers are reimbursed for covered services with payments issued by Valley Health Plan accompanied by a remittance advice (RA). The RA lists in detail all of the claims paid with the check and the status of the processed claims. The RA report shows the amount paid and the amounts denied for each service line. Denial codes with their full explanation appear at the bottom of the RA report.

**Reason Codes**

HIPAA requires all payers, including Valley Health Plan, to use nationally recognized reason and remark codes instead of proprietary codes to explain any adjustment in claim payment. CMS (Centers for Medicare and Medicaid Services) maintains the remittance advice remark code list. The Health Care Code Maintenance Committee maintains the health care claim Adjustment Reason codes list. Both lists are available at <<http://www.wpc-edi.com/codes/Codes.asp>> and are updated throughout the year.

## COORDINATION OF BENEFITS

### Medi-Cal Managed Care

Medi-Cal Managed Care is the payer of last resort. In the event a Medi-Cal Member is covered by both VHP and another health insurance program, the other insurance program is the primary insurance payer. The provider should attempt to recover from any other health insurance program for which the Member is eligible, including Medicare, before submitting a claim to VHP. For Medi-Cal claims, the provider should consult the Medi-Cal/EDS Provider Manual.

### VHP Commercial

VHP will coordinate benefits for Members who are covered under two or more health plans. When there is Coordination of Benefits (COB), the health care plan shares the cost of authorized services covered under the health plan. Members may be able to receive up to 100 percent coverage. Other coverage includes benefits available through commercial insurance companies; prepaid health plans (PHPs) or Health Maintenance Organizations (HMOs), as well as any organization that administers a health plan for professional associations, unions, fraternal groups or employer-employee benefit plans, including self-insured and self-funded plans.

When submitting a claim to VHP for any services partially paid or denied by the Member's primary health insurance, a copy of the coverage's Explanation of Benefits (EOB), Remittance Advice (RA) report or denial letter must accompany each claim for services within VHP's scope of benefits. The EOB or denial letter must state the following:

- a) Name and address of insurance plan
- b) Recipient's name and policy number
- c) Statement of denial or payment amount
- d) Procedure or service rendered –and denial date
- e) Date of Service
- f) Provider information – name, address, etc.

## THIRD-PARTY LIABILITY INSURANCE

### Medi-Cal Managed Care

A Plan who has paid for services to a provider for a Medi-Cal Member subsequently discovered to be covered by a Member's disability insurance, casualty settlement or other third-party liability may now file a lien against the judgment, award or settlement for all fees charged.

### VHP Commercial

The provider will make every attempt to identify other third-party coverage (e.g., health care coverage, worker's compensation, automobile or other liability insurance). The provider agrees to bill the appropriate 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.

### Provider Dispute Process

As required by California Assembly Bill 1455, VHP has established a fast, fair and cost-effective dispute resolution mechanism that complies with the DMHC requirements. The dispute process as described in the Provider Relations

section of this Manual offers providers a method of resolving claims disputes. A claim dispute must be submitted in writing to:

Valley Health Plan  
Attn: Provider Relations Dispute Resolution  
P. O. Box 28387  
San Jose, CA 95159

### Claims Tracers and Inquiry Process

The provider may submit a letter or a claim with “Tracer” stamped on the claim form when inquiring about claims status, problems regarding claims processing or when resubmitting claims. The claim inquiry or tracer should be used to request any of the following:

- Resubmission of a denied claim
- An adjustment such as overpayment or underpayment
- Tracer or research of claim status that has not appeared on the RA report
- Further action after claim appears on the RA report as paid or denied.

**VHP Commercial**  
P.O. Box 26160  
San Jose, CA 95159

**VHP Medi-Cal**  
P.O. Box 28407  
San Jose, CA 95159

**VHP Healthy Families/Healthy Kids**  
P.O. Box 28410  
San Jose, CA 95159

### Claims Overpayments

- Notice of Overpayment of Claim.** 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.
- Contesting a Notice of Overpayment.** If the provider contests VHP’s notice of overpayment, the provider, within 30 working 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.
- No Contest.** If the provider does not contest VHP’s notice of overpayment of a claim, provider must reimburse VHP within 30 working days of the provider’s receipt of the notice of overpayment.
- Offsetting Claims Payments.** VHP may offset an uncontested notice of overpayment against a provider’s current claim submission when:
  - The provider does not reimburse VHP within the 30 working days of receipt of the notices, and
  - VHP has a contract with provider specifically authorizing VHP to offset an uncontested notice of overpayment of a claim from the provider’s current claims submissions.

If this happens, VHP will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the current claim(s).

## **: Member Benefits**

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**Members must present their VHP or SCFHP identification card whenever they seek services. Providers must check eligibility at each visit.**

**Possession of a VHP or SCFHP identification card does not guarantee eligibility.**

### **Section 4**

#### **Valley Health Plan Commercial**

To confirm a VHP Commercial Member's eligibility, please refer to Valley Express on-line eligibility system or you can contact the VHP Member Services Department Monday through Friday, 9 am to 5 pm at: **(408) 885-4760 or (888) 421-8444**

Outside of normal business hours, please leave a message and a representative will return your call on the next business day.

#### **Santa Clara Family Health Plan–Network 2**

Eligibility may be verified online at [www.scfhp.com](http://www.scfhp.com) or by contacting SCFHP 24-Hour Automated Eligibility Verification Line at 1-800-720-3455 or SCFHP Member Services Department, Monday-Friday, 8am to 5 pm at 1-800-260-2055.



## Member Benefits

Benefits, services and coverage will include, but are not be limited to, the following list of medically necessary services. Any discrepancies between this summary and the Member's specific coverage will be resolved in favor of the terms of the Member's Evidence of Coverage and Disclosure Form.

Service (Please refer to Member's Evidence of Coverage and Disclosure Form)	VHP Commercial	Santa Clara Family Health Plan –Network 2	
		Medi-Cal Managed Care	Healthy Families & Healthy Kids
Abortions	Yes	Yes	Yes
Acupuncture	Yes Up to 20 visits/year Copay \$10/visit	Refer to Medi-Cal /EDS	Yes 20 visits/year, \$5/visit
AIDS/HIV Testing	Yes	Yes	Yes
Alcohol Abuse Treatment	Yes	Yes Refer to Medi-Cal	Yes Refer to SCFHP
Allergy Testing and Treatment	Yes	Yes	Yes
Alpha Fetal Protein (AFP) Testing	Yes Refer to State Program	Yes Refer to State Program	Yes Refer to State Program
Ambulance – Emergency Transport	Yes	Yes	Yes
Amniocentesis	Yes	Yes	Yes
Anesthesiology	Yes	Yes	Yes
Artificial Insemination Services	Yes (See Section 4A)	No	No
Audiology	Yes	Yes	Yes
Autologous Blood	Yes	Yes	Yes
Biofeedback	Yes	No	Yes 8 visits, \$5/visit
Blood & Blood Products	Yes	Yes	Yes
Burn Care	Yes	Yes	Yes
CT Scan	Yes	Yes	Yes
California Children's Services (CCS)	No	Refer to CCS	Refer to CCS
Chemical Dependency	Yes	Yes Refer to Medi-Cal	Yes Refer to SCFHP

Service (Please refer to Member's Evidence of Coverage and Disclosure Form)	VHP Commercial	Santa Clara Family Health Plan –Network 2	
		Medi-Cal Managed Care	Healthy Families & Healthy Kids
Chemotherapy	Yes	Yes	Yes
Children's Health & Disability Program (CHDP)	N/A	Yes	N/A
Chiropractic Care	Yes 20visits/year, \$10/visit	Refer to Medi-Cal/EDS	Yes 20 visits/year, \$5/visit
Contact Lenses	No	Refer to Medi-Cal/EDS	Refer to VSP
Contact Lenses Post Cataract Surgery	Yes	Yes	Yes
Contraceptives	Yes	Yes	Yes
Corrective Appliances	Yes	Yes	Yes
Dental Care; for TMJ services	See Section 4A	Refer to Medi-Cal/EDS	Refer to SCFHP
Dental Surgery (Facility Fee and Anesthesia Only)	Yes	Yes	Yes
Dermatology Services	Yes	Yes	Yes
Diabetic Supplies/Equipment	Yes	Yes	Yes
Diabetic medications dispensed by Pharmacy	Yes, Plan Pharmacy	Refer to SCFHP	Refer to SCFHP
Diagnostic Laboratory Services	Yes	Yes	Yes
Dialysis	Yes	Yes	Yes
Durable Medical Equipment (DME)	Yes	Yes	Yes
Emergency Services	Yes	Yes	Yes
Emergency Services outside of Santa Clara County	Yes	Refer to SCFHP	Refer to SCFHP
Employment Physical	No	No	No
Endoscopic Studies	Yes	Yes	Yes
EPSDT ( Early Periodic Screening, Diagnosis & Treatment)	No	Refer to Medi-Cal	Yes
Experimental Procedures/Therapy	Yes	No	No

Service (Please refer to Member's Evidence of Coverage and Disclosure Form)	VHP Commercial	Santa Clara Family Health Plan –Network 2	
		Medi-Cal Managed Care	Healthy Families & Healthy Kids
	(See Section 4A)		
Eyeglass Frames	No	No Refer to Medi-Cal EDS	No Refer to VSP
Eyeglass Lenses	No	No Refer to Medi-Cal	No Refer to VSP
Eyeglass Lenses Post Cataract Surgery	Yes	Yes	Yes
Family Planning Services	Yes	Yes	Yes
Fetal Monitor/Non-Fetal Stress Test	Yes	Yes	Yes
Genetic Counseling Services	Yes	Yes	Yes
Gynecology Services	Yes	Yes	Yes
Health Education and Health Promotion Services	Yes	Yes	Yes
Hearing Aid	Yes (Once every 36 months up to a maximum of \$1,000)	Yes	Yes
Hemodialysis & Peritoneal dialysis	Yes	Yes	Yes
Home Health Care	Yes	Yes	Yes
Home Health Postpartum Visit	Yes	Yes	Yes
Hospice Care	Yes	Yes	Yes
Hospital Care (Inpatient)	Yes	Yes	Yes
Hospital Care (Outpatient)	Yes	Yes	Yes
House Calls	No	No	No
Immunizations and Injections	Yes	Yes	Yes
Infertility Diagnosis and Treatment	Yes	No	No
	(See Section 4A)		
Laboratory	Yes	Yes	Yes
Mammography Examination	Yes	Yes	Yes
Maternity Care	Yes	Yes	Yes
Medical Supplies and Equipment	Yes	Yes	Yes
Mental Health Services (Inpatient)	Yes	Refer to Medi-Cal/EDS	Refer to SCFHP

Service (Please refer to Member's Evidence of Coverage and Disclosure Form)	VHP Commercial	Santa Clara Family Health Plan –Network 2	
		Medi-Cal Managed Care	Healthy Families & Healthy Kids
Mental Health Services (Outpatient)	Yes	Refer to Medi-Cal/EDS	Refer to SCFHP 20 visits/year, \$5/visit
MRI	Yes	Yes	Yes
Newborn Circumcision	Yes	No	No
Non emergent medically necessary Transportation	Yes	Yes	Yes
Obstetric Services & Prenatal Care	Yes	Yes	Yes
Optometry Services – Refractive Exam	Yes	Refer to SCFHP	Refer to VSP
	(See Section 4A)		
Orthotics	Yes	Yes	Yes
Oxygen	Yes	Yes	Yes
Pediatric Health Examinations	Yes	Yes	Yes
Pediatric and Well-Child Care	Yes	Yes	Yes
PET Scans	Yes	Yes	Yes
Physical Examinations	Yes	Yes	Yes
Physical, Occupational, Speech and Respiratory Therapy Services	Yes	Yes	Yes
Physician and Surgeon's Care	Yes	Yes	Yes
Podiatry Services	Yes	Yes	Yes
Prayer and Spiritual Healing	No	No	No
	Refer to Medi-Cal		
Prescription Drugs	Yes, Plan Pharmacy	Refer to SCFHP	Refer to SCFHP
Preventive Care	Yes	Yes	Yes
Primary Care Physician Services	Yes	Yes	Yes
Prosthetics	Yes	Yes	Yes
Radiology	Yes	Yes	Yes
Reconstructive Surgery (Medically Necessary only)	Yes	Yes	Yes
Skilled Nursing Care	Yes	Yes	Yes
Second Opinions	Yes	Yes	Yes
Speech Therapy	Yes	Yes	Yes

Service (Please refer to Member's Evidence of Coverage and Disclosure Form)	VHP Commercial	Santa Clara Family Health Plan –Network 2	
		Medi-Cal Managed Care	Healthy Families & Healthy Kids
Sterilization	Yes	Yes	Yes
Sterilization Reversal	No	No	No
Substance Abuse Services (Inpatient Detoxification)	Yes	Refer to Medi-Cal	Refer to SCFHP
Substance Abuse Services (Outpatient)	Yes	Refer to Medi-Cal	Yes Refer to SCFHP 20 visits/year, \$5/visit
Surgery	Yes	Yes	Yes
Transportation - Non-Emergency, Medical	Yes (See Section 4A)	Yes (See Section 4A)	Yes (See Section 4A)
Urgently Needed Services	Yes	Yes	Yes
Urgently Needed Services Out of Services Area	Yes	Refer to SCFHP	Refer to SCFHP
Well-Woman Examination	Yes	Yes	Yes

Note: All services are subject to Member eligibility at the time of service.

### VHP Commercial - Principal Limitations

1. Covered Services are available only through Plan Providers in the Network (unless such care is rendered as Emergency Services or is Prior Authorized);
2. Covered Services provided by Non-Plan Providers are limited to those services rendered as Emergency or Urgently Needed Services or for which you have obtained Prior Authorization before services are rendered;
3. If you seek Routine Care, elective Medical Services or follow up care from Non-Plan Providers without an Authorization, VHP will not pay for your care and you will be financially responsible.
4. In the event of major disasters, epidemic, labor disputes, war, and other circumstances beyond our control, VHP Providers will provide benefits to the extent practical, according to their best judgment within the limitations of available facilities and personnel. We will have no liability for delay or failure to provide services under such conditions;
5. You may refuse to accept procedures or treatment recommended by your Plan Physician. If you refuse to follow a recommended treatment or procedure, your Plan Physician will inform you whether or not your Plan Physician believes there is an acceptable alternative treatment. You may seek a second medical opinion from another VHP Provider. If you still refuse the recommended treatment or procedure, VHP has no further responsibility to provide you care for the condition involved;
6. VHP reserves the right to Coordination of Benefits Reimbursement as outlined in the Agreement. Your Benefits are limited to such extent. As a Member, you have an obligation to cooperate and assist us to coordinate Benefits by providing information to all health service providers on any other coverage you and your Dependent(s) have;
7. VHP reserves the right to seek Third Party Reimbursement as outlined in the Agreement. Your Benefits are limited to such extent. As a Member, you have the obligation to cooperate fully in our efforts by signing any forms necessary to assist us in obtaining this recovery;
8. Acupuncture services are limited to 20 visits per Calendar Year;
9. Chiropractic services are limited to 20 visits per Calendar Year;
10. 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 aides or devices prescribed;
11. Weight Watchers treatment reimbursement is limited to one (1) twelve (12) week session per calendar year.

### VHP Commercial - Principal Exclusions

1. Services and charges from the time the Member refuses to accept a recommended treatment or procedure after being advised by the treating Physician that no professionally acceptable alternative exist;
2. Services furnished by a facility which is primarily a place for rest, a place for the aged, a nursing home or any facility of like character, except as specifically provided as Covered Benefits;
3. Services not Medically Necessary. The determination whether a service or supply is Medically Necessary is made by the Medical Director based on an objective review and subject to Grievance procedures;
4. Services rendered by Non-Plan Providers except in an Emergency or upon Prior Authorization by the Medical Director;
5. Services rendered when not an Eligible Member, prior to the effective date or after the termination date;
6. Services that are court ordered or as a condition of incarceration, parole or probation;
7. Services which exceed the limitations or fail to meet the conditions of Covered Services;
8. Charges for any treatment for addiction to, or dependency on, tobacco or tobacco products, except for the smoking cessation programs that are Benefits of the health education and health promotion services;

9. Charges for services for which the Member would not be obligated to pay in the absence of the Agreement or which are provided to the Member at no cost;
10. Acupuncture services unless specifically listed as a Covered Service;
11. Administration of prescription legend drugs or injectable insulin;
12. Anorectics or any other drug used for the purpose of weight control, unless Medically Necessary;
13. Artificial Insemination - any service, procedure, or process which prepares the Member to receive conception by artificial means (except as specified as a Covered Service) such as services related to prescription drugs not on Plan Formulary, donor sperm, sperm preservation, or washing or concentration procedures;
14. Mental Health Services that are court ordered, or as a condition of incarceration, parole or probation, except if a Plan Physician determines that the services are Medically Necessary Covered Services;
15. Mental training and modification including but not limited to hypnotherapy, education, vision therapy, play therapy, and sleep therapy;
16. Cancer clinical trial services except specifically listed as a Covered Service;
17. Chiropractic services except specifically listed as a Covered Service;
18. Cosmetic, plastic or reconstructive surgery except as specified as a Covered Service;
19. Cosmetics, herbal products and treatments, dietary supplements, health or beauty aids;
20. Custodial or Domiciliary Care except as required under Hospice;
21. Dental Services except authorized: (1) services for treatment or removal of tumors; (2) physicians' services or physician X-ray exams for the treatment of accidental injury to natural teeth; (3) surgery on the maxilla or mandible that is Medically Necessary to correct temporomandibular joint disease (TMJ) or other medical disorders within the limitations of eight hundred dollars (\$800); and/or (4) services for intra-oral devices and associated services for the treatment of TMJ within the limitations of eight hundred dollars (\$800); or (5) services in connection with accidental fractures of the jaw;
22. Dependent coverage for Groups with Subscriber Coverage only;
23. Devices or appliances except Medically Necessary Diabetic, Prosthetic, and Orthotic Devices. Specifically excluded devices include, but are not limited to, the following: over the counter items, elastic stockings, garter belts, and similar devices; experimental or research equipment; devices not medical in nature; modifications to a home or automobile; deluxe equipment, non-standard equipment, more than one piece of equipment that serves the same function; more than one device for the same part of the body; and electronic voice producing machines;
24. Educational services except as expressly provided as Covered Benefits (health education and promotion services);
25. Emergency room services for non-Emergency care;
26. Exercise, recreation, self-help, hygienic, and beautification classes and equipment;
27. Experimental or Investigational Treatment except as expressly provided as a Covered Service (Cancer Clinical Trial Services or a Member with a Life-Threatening or Seriously-Debilitating condition may request an independent medical review as described under Independent Medical Review Section);
28. Gastric bubble, gastroplasty, gastric bypass, bariatric surgery, and gastric stapling except when determined to be Medically Necessary by the VHP Medical Director;
29. Hearing aids and hearing aid services, including the furnishing, fitting, installing, or replacing of hearing aid, unless specifically listed as a Covered Service;
30. Hearing examinations to determine the need for hearing correction for Members over eighteen (18) years unless Medically Necessary;
31. Human Chorionic Gonadotropin (HCG) Injections;

32. Human Growth Hormone (HGH), except for Members with confirmed HGH deficiency; and Covered Services are recommended by a Plan Specialist;
33. Infertility services unless specified as a Covered Service, please see Combined Evidence of Coverage and Disclosure Form;
34. Liposuction;
35. Massage therapy;
36. Military service connected disability care for which a Member is covered or is eligible for such care through another group, whether insured or self-insured;
37. Organ, tissue and bone marrow transplants considered Experimental or Investigational Treatment;
38. Organ, tissue and bone marrow transplants treatment, including medical and Hospital Services for a Member who is a donor or prospective donor when the recipient of an organ, tissue or bone marrow transplant is not a Member. Covered Services for a non-Member donor must be directly related to a covered transplant of a Member and are covered up to twelve (12) months from the date of the transplant surgery;
39. Out-of-Network opinions, except as a Covered Benefit. Independent Medical Review of denial of coverage by a Plan Provider for Experimental and Investigational Treatment is available; refer to the Independent Medical Review Section;
40. Over the Counter (OTC) drugs, orthotics, supplies and equipment;
41. Penile implants and services related to the implantation of penile prostheses, except as Medically Necessary to treat direct physical trauma, tumor, or physical disease to the circulatory system or the nerve supply;
42. Personal lodging, meals, travel expenses and all other non-medical expenses;
43. Personal or comfort items which are non-medical, environmental enhancements or environmental adaptations, modifications to dwellings, property or motor vehicles, adaptive equipment and training in operation and use of vehicles;
44. Physical exams, evaluations and reports including those for employment, insurance, licensing, school, sports, recreation, premarital purposes, or required for or by court proceedings, unless timing and scope coincide with covered periodic health appraisal exams;
45. Prescription drugs and accessories not Medically Necessary or in accordance with professionally recognized standards of care; non-prescription drugs or medications, including over the counter drugs; non-FDA Approved Drugs; Generic equivalents not approved as substitutable by the FDA; non-FDA approved Treatment Investigational New Drugs; National Cancer Institute Group C cancer drugs that are used for purposes other than those purposes approved by the FDA or the National Cancer Institute;
46. Reversal of voluntary sterilization or of voluntary induced infertility;
47. Routine foot care, including trimming of corns, calluses and nails, unless Medically Necessary;
48. Sexual Reassignment surgery, related services and supplies except when Medically Necessary due to congenital defects;
49. Surgical treatment to correct a congenital or developmental abnormality unless Medically Necessary for Reconstructive Surgery;
50. Temporomandibular Joint (TMJ) Disorders Services that are not Medically Necessary and the cost of TMJ associated services and any intra-oral positioning devices or related services that are more than the lifetime limitation of eight hundred dollars (\$800.00);
51. Transportation services unless Medically Necessary and authorized by the Medical Director or unless necessitated by an Emergency;



52. Treatment of alcohol, drug, or chemical abuse or dependency, including non-medical ancillary services and rehabilitation services in a specialized inpatient or residential facility (sober living environment) except as specified as Covered Benefits;
53. Vision care except as specified as Covered Benefits;
54. Vocational Rehabilitation;
55. Weight control or weight loss treatments or supplies unless Medically Necessary, except as specifically provided as Covered Benefits.

#### **Santa Clara Family Health Plan–Network 2 - Principal Exclusions**

The following are excluded from the Managed Medi-Cal, Healthy Families and Healthy Kids Benefit Plans:

1. Services that are not benefits of the California Medical Assistance (Medi-Cal) Program.
2. Services not received from or prescribed, referred, or authorized by the Member's Plan primary care physician, except in the case of an emergency, for Family Planning Services or when specifically authorized in advance by the primary care physician or VHP.
3. Services rendered prior to the effective date of Membership or after the date Membership terminated.
4. Services that are not medically necessary.
5. Dental surgery, treatment or care (including such for overbite or underbite, maxillary and mandibular osteotomies or temporomandibular joint syndrome, except when medically necessary); dental x-rays, supplies or appliances (including occlusal splints); and all associated expenses arising out of such dental surgery, treatment or care, including hospitalization. Note: Hospital, physician, and dental services and supplies including anesthesiology services recommended by a participating physician and approved in writing in advance by VHP that are deemed necessary to safeguard the health of a Member because of a specific non-dental physiological impairment are covered.
6. Custodial care, domiciliary care, respite care or rest cures.
7. Personal comfort and convenience items or services such as televisions, telephones, barber or beauty services, guest services and similar incidental services and supplies that are not medically necessary, as well as air-conditioners, even though prescribed by a physician.
8. Health services for cosmetic procedures, including, but not limited to, pharmacological regimes, nutritional procedures or treatments, plastic surgery and non-medically necessary reconstructive surgery.
9. Health services for procedures intended primarily for the treatment of morbid obesity, including gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, exercise programs and weight-loss programs, even when prescribed by a physician, unless medically necessary and approved by the primary care physician and VHP.
10. Experimental services are not covered, unless they are benefits of the California Medical Assistance (Medi-Cal) Program.
11. Investigational services are not covered, unless the conditions of Title 22 California Code of Regulations, Section 51303 (h) are met and prior authorization is received from VHP.
12. Health services for removal of an organ from a Member for purposes of transplantation into another person who is not a Member.
13. Health services for infertility and treatment, including in vitro fertilization, gamete intra-fallopian transfer (GIFT) embryo transport and donor semen.
14. Non-medically necessary amniocentesis.
15. Health services for sex transformation operations.
16. Health services for reversal of voluntary sterilization.

17. Travel or transportation expenses, even though prescribed by the primary care physician or other participating physician.
18. Health services for military-service-related disabilities to which the Member is legally entitled and for which facilities at the Veterans Administration are reasonably available to the Member.
19. Inpatient Mental Health Services or health services provided by a chemical dependency treatment or rehabilitation program.
20. Physical, psychiatric or psychological examinations or testing, vaccinations, immunizations or treatments related to career education, employment, insurance, marriage, adoption, or judicial or administrative proceedings or orders, or for medical research or to obtain or maintain a license of any type.
21. Use of the hospital emergency rooms for non-emergent or non-urgent (routine) care.
22. Health services otherwise covered under this contract when the Member has refused to comply with the service or treatment recommended by a participating physician or other participating health care professional.
23. Inpatient pain management program or any pain management program in the absence of a diagnosed medical condition.
24. Out-of-Network Services

Services that could reasonably have been foreseen before leaving the service area are not considered either emergency or urgent care and will not be covered. For example, if the Member requires routine dialysis or oxygen therapy the Member should either obtain the necessary therapy prior to leaving the service area or obtain an authorization for this care while outside the service area.

The Member will be financially responsible for Services: received out of the network that could have been foreseen; not prior authorized; not considered urgently needed services or emergency services.

Maternity services rendered when the Member has traveled outside the service area for the express purpose of obtaining medical services are covered only if such services have been prior authorized by VHP. If a Member delays receiving or arranging for this care until out of the VHP network, VHP will not pay for that care, and the Member will be financially responsible.

### Member Rights and Responsibilities

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.

### **Grievance Process**

VHP encourages its providers to resolve all Member grievances at the point of service whenever possible. Members are invited to submit Grievances, which are at VHP's website in English, Spanish and Vietnamese at [www.valleyhealthplan.org](http://www.valleyhealthplan.org) in the For Member section.

Member grievances not resolved at the point of service will be resolved through the grievance process, unless otherwise indicated by the Member, and should be referred to the Member Services Department. Members may either call or write their grievance.

### **Commercial Members**

A Member Services representative will assist the Member in resolving the complaint. †

**Member Services Department**  
Valley Health Plan  
2480 North 1st Street, Suite 200  
San Jose, CA 95131  
(408) 885-4760 or 1 (888) 421-8444

### **Santa Clara Family Health Plan–Network 2**

A SCFHP Member Services representative will assist the Member in resolving the complaint.

**SCFHP Member Services Department**  
Santa Clara Family Health Plan  
210 East Hacienda Avenue Campbell, CA 95008  
1-800-260-2055

All Members have the right to contact the California Department of Managed Health Care with a grievance.

**Department of Managed Health Care (DMHC)**  
1-888-446-2219

## Primary Care

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The Primary Care Physician (PCP) is responsible for providing and coordinating covered services for all Valley Health Plan Members who are assigned to that provider. VHP emphasizes the importance of a positive relationship between the PCP and the Member. Every effort will be made to ensure continuity of care and the provision of quality and cost-effective health care to VHP Members.

### Section 5:

The primary care physician is gatekeeper in charge of coordinating the delivery of all health care services to a Member, including referrals to appropriate specialists. This is accomplished through access to care 24 hours a day, 7 days a week. The PCP is responsible for the following:

- a) Routine health care services
- b) Preventive medical services, see Section 14 Forms & Attachments
- c) Health risk assessments
- d) Coordination of referrals
- e) Treatment planning
- f) Follow up to acute hospitalization and/or emergency room visit
- g) Education of Member about access to care

### Scope of Primary Care Physician Practice

The primary care physician may be a Internist, Pediatrician, Family Practice or General Practice provider. In addition to basic medical and preventative health care, an Obstetrician/Gynecologist may provide gynecological or obstetrical care. Members under the care of other primary care physicians may self-refer for OB/GYN services.

The scope of practice of a PCP will include, but not be limited to diagnosis and treatment in the following areas:

- Acute and chronic allergies and asthma
- Common skin lesions (rashes, warts, keratoses) and skin tags
- Skin biopsy and excision as appropriate and if experienced
- Diabetes mellitus controlled with diet, oral medication or insulin
- Thyroid dysfunction
- Peptic ulcer disease
- Gastroenterologic reflux
- Irritable bowel syndrome
- Differential diagnosis of abdominal pain including gynecological disorders
- Hemorrhoids
- Hepatitis and cirrhosis
- Routine pelvic examinations with PAP smears.
- Sexually transmitted diseases
- Diagnosis of abnormal vaginal bleeding
- Diagnosis of pregnancy
- Family planning
- Anemia
- Hemoglobinopathies
- Diagnosis and treatment of common infectious diseases
- Testing and initial evaluation of HIV-positive patients

- Tuberculosis prophylaxis
- Headaches, including migraines and those caused by muscle tension
- Seizure disorders, stable and controlled
- Corneal abrasions
- Conjunctivitis
- Stye
- Visual acuity
- Strains, sprains, tendonitis, bursitis
- Splinting of sprains, simple fractures
- Initial evaluation and treatment of lower back pain
- Diagnosis and treatment of acute upper respiratory conditions
- Diagnosis and treatment of chronic respiratory conditions such as asthma and emphysema
- Otitis media
- Otitis externa
- Tonsillitis
- Initial evaluation and treatment of musculo-skeletal disorders
- Suturing of simple lacerations
- Incision & Drainage of cysts and abscesses
- Urinary tract infections
- Kidney stones
- Uncomplicated hypertension
- Hyperlipidemia
- Stable angina
- Evaluation of undifferentiated symptoms such as abdominal or chest pain
- EKG interpretation
- Peripheral vascular disease (venous and arterial)
- Psychiatric assessment and initial intervention
- Recognition and initial management of drug and alcohol dependence
- Recognition and treatment of depression

For Clinical Practice and Referral Guidelines, see Section 14 of the Manual for a snapshot of its contents. To view it in its entirety on-line, go to the For Providers section of [www.valleyhealthplan.org](http://www.valleyhealthplan.org) or call Provider Relations at 408-885-2221.

### 120-Day Assessment

The Medi-Cal Managed Care and Healthy Families Programs require that all Members new to the Plan be contacted to arrange an initial history and physical examination within the first 120 days of enrollment unless the Primary Care physician already has a record of a complete history and physical within the previous year.

The primary purpose of preventive health examinations is to maintain and improve health by early detection of disease and to prevent increased risk of subsequent disease. A preventive orientation and early intervention approach for assessing patients' current and future health care needs may also reduce unnecessary emergency room use and after-hour calls. An initial history and physical examination (H&P) will allow primary care physicians to develop a relationship with adult Members (ages 18 and over) in a non-crisis situation. This preventive medicine program includes general health promotion, appropriate immunizations, early diagnosis and prompt therapy of chronic medical conditions.

Valley Health Plan requires that an initial H & P be performed for each Member assigned to a PCP. Every exam begins with a history that includes the medical, social and family background as well as habits (smoking, alcohol, sexual). A minimum preventive medical examination typically includes the patients' history, weight, height, blood pressure, pulse, and a comprehensive physical exam. Patients should be instructed on self-examination. Contingent on the history and physical exam of the patient, other tests and examinations may be performed.

### Timely Access Guidelines

The State of California regulations require that health plans meet the following Access Guidelines for the following services. VHP works with our providers to ensure that these Access Guidelines are being met.

Appointment Scheduling Maximum Waiting Time	
Emergency Services	Immediately
Urgent Care appointments that do not require prior authorization (PCP)	Must offer the appointment within 48 hours of request
Urgent Care appointments for that require prior authorization	Must offer the appointment within 96 hours of request
Non-Urgent appointment for Primary Care (PCP)	Must offer the appointment within 10 business days of the request
Managed Care MediCal and Healthy Kids members Initial Health Assessment.	Adults and Children 18 mos or older 120 days of joining. Children under age 18 mos 60 days.
Non-Urgent appointments with Specialist Physicians (SCP)	Must offer the appointment within 15 business days of a request
Non-Urgent appointments for Ancillary Services (for diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within 15 business days of request
Waiting time in provider office (to see provider)	Maximum 30 minutes
Accessibility of Obstetrical Care	
Emergency Exam	Immediately
Initial visit	Within 30 calendar days
Non-Urgent subsequent Exams	Within 30 calendar days
Availability of Behavioral Health Care	
Life-threatening emergency	Immediately
Non-life threatening emergency	Within 6 hours
Urgent Care Appointments	Must offer the appointments within 48 hours of request
Non-Urgent Care appointments with a non-physician Mental Health Care Provider	Must offer the appointment within 10 business days of request
Non-Urgent care appointments with a Physician Mental Health Care Provider	Must offer the appointment within 15 business days of request
Access to Follow-up Care After Hospitalization for mental illness	<b>Must Provide Both:</b> One follow-up encounter with a mental health provider within 7 calendar days after discharge. <b>PLUS:</b> One follow-up encounter with a mental health provider within 30 calendar days after discharge.
After-hours Care	
	Call the 24/7 Medical Advice Line at 1.866.682.9492 (toll-free) for all holidays, weekends and after-hours care.

All providers must have coverage 24 hours a day and 7 days a week. 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
- Length of wait time for a return call from provide



## : Ancillary Services for Chiropractic and Acupuncture

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### Accessibility Standards

Chiropractic and Acupuncture Providers are required to adhere to the Timely Access to Non-Emergency Health Care Services (1300.67.2.2), subsections (c) (1), (3), (4), (7), (9), and (10), and subsections (d) (1) and (g) (1). Specifically these services shall employ an answering service or telephone answering machine during non-business hours, which provide instructions regarding how a member may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

## Mental Health & Substance Abuse Services (Commercial Plan Only)

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### Mental Health Services

Valley Health Plan Commercial Members are eligible to receive the following Outpatient Counseling services. The following Outpatient Services do NOT require an authorization; Member must see a VHP Network provider:

**Outpatient Mental Health Services performed by a LCSW, MFT or Psychologist**

- Evaluations, crisis intervention, and short-term therapy.
- Counseling services including, but not limited to assessment, diagnosis, and treatment planning (if couples or family counseling, all attendees must be eligible VHP Members).
- Psychological and neuropsychological testing performed by a Psychologist.
- Individual and group psychotherapy.
- Applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practical, the functioning of an individual with Pervasive Developmental Disorder or Autism.

Valley Health Plan Commercial Members are eligible to receive the following services. These services require Prior Authorization; Member must see a VHP Network provider:

- Inpatient Mental and Behavioral Health Services
- Psychiatrist visits for evaluation and treatment.
- Crisis intervention, crisis residential services and partial hospital services.

### Substance Abuse Treatment Services

The Member may contact the Gateway Program at 1-800-488-9919.

A Member may request Substance Abuse treatment services directly from the Gateway Program. Gateway will assess the Member's needs and if appropriate, accept for treatment. The Gateway Program will notify VHP Utilization Management (UM) Department of a referral on the first business day after the referral.

### Outpatient Substance Abuse Services

- Diagnosis and counseling for alcohol and/or drug dependency and medical treatment for withdrawal symptoms (includes Methadone maintenance).

### Inpatient Substance Abuse Services

- Short term acute detoxification.

### Residential Recovery Services

- Sober Living Environments are not covered benefits

### Mental Health Referral Guidelines

SCFHP Members receive Mental Health Services through SCFHP. To arrange for services, contact SCFHP at 1(800) 704-0900.

For Commercial Members, Primary Care Physicians must complete a “Treatment Authorization Request for Services” to a Network psychiatrist and fax it to the UM Department at (408) 885-4875.

The “Treatment Authorization Request for Services” must include:

- All information in the "Patient Information" box
- Request Type (Check One)
- Requested Provider
- Services Requested
- Requesting Provider/Physician (Please print)
- MD Signature
- Date

VHP will review the request and authorize the services, if appropriate. The authorization will cover a specific time period and number of visits. The PCP, Network Mental Health Specialist and the Member will receive a written notice of the authorization or denial. Except in emergencies, prior authorization is required for psychiatric services.

Mental Health Specialists may request an authorization for treatment or continuation by providing a Treatment Plan to UM Department for Mental Health prior to Services. The UM Department may authorize further visits after review of the Treatment Plan. The PCP, Mental Health Specialist and the Member will receive a written notice of the authorization or denial.

Fax Treatment Plans to VHP UM Department at (408) 885-4875.

### Mental Health Pharmaceuticals

Formulary Drug prescriptions are filled at VHP Network Pharmacies.

To Request Non-Formulary Drugs, a Physician must complete the “Non-Formulary Drug Request” form (see-Section 14 Forms & Attachments and mail to VHP Utilization Management Department or fax to (408) 885-4875. Upon receipt, the UM Department will review and process the request within 48 hours or two working days.

## Urgent and Emergency Care

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### Urgent Care

Members who urgently need services should call the 24/7 Medical Advice Line at 1.866.682.9492 (toll-free) for all holidays, weekends and after-hours care, or their Primary Care Physician

Urgently needed services are covered when:

- a) The Member's condition meets the definition of urgently needed services (see Section 15: Glossary of Terms), and
- b) Members use the network of VHPs Urgent Care Locations or
- c) The Member obtains authorization from the VHP Utilization Management (UM) Department (or the advice nurse) before seeking treatment from a non-VHP provider when the Member is temporarily out of the service area and medical care cannot be delayed until the Member returns.

### Emergency Services

In an emergency, VHP Members should call 911 or go to the nearest emergency room.

Emergency services are covered when furnished by VHP providers or non-VHP providers if the following requirement is met:

“Emergency Services”, as set forth in Title 22, California Code of Regulations (“CCR”), section 51056, and California Health and Safety Code section 1317.1, means those services required for alleviation of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- a) placing the patient's health (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- b) serious impairment to bodily functions; or
- c) serious dysfunction of any bodily organ or part.

Emergency Services also includes screenings, examinations, and evaluations for the purpose of determining whether a psychiatric emergency condition exists, and for which treatment is necessary to relieve or eliminate the psychiatric emergency condition.

The final determination as to whether such services were emergency services rests solely with VHP.

When it is necessary to receive emergency services from a non-VHP provider, Members should present their VHP ID card and ask the provider or someone acting on the Member's behalf to call VHP at 1-888-421-8444. VHP must be notified within 48 hours or as soon as reasonably possible.

Members who have certain chronic illnesses, require extensive follow-up or are following a complicated medical regimen are placed on a log for Case Management. These Members are followed by one of the nurse case managers to ensure and coordinate comprehensive care.

Members who have been in the hospital for more than five days or Members who are readmitted to the hospital with the same diagnosis within 30 days may be added to the Case Management log. All case management Members are followed closely by the case manager and the Medical Director.

### **Inpatient Reviews**

Case Management reviews all inpatient admissions to hospitals, skilled nursing facilities and other clinical settings for medical necessity and the appropriateness of care. During concurrent review, a nurse may:

- Obtain and document information for decisions of medical necessity.
- Determine the probable length of stay, based on appropriate guidelines for the Member's diagnosis
- Evaluate, with facility staff, the Member's discharge needs
- Coordinate the repatriation of Members to VMC.

If an admission or continued stay does not appear to meet medical necessity guidelines, the VHP Medical Director will review the records. Medical necessity is evaluated utilizing nationally recognized standards. The UM Department may authorize transfers and referrals for post-discharge services, such as home health, DME or rehabilitative therapies.

### **SCVMC Discharge Planning**

When a Member is admitted to Santa Clara Valley Medical Center, an SCVMC case manager will coordinate post discharge services, such as home health care, durable medical equipment or skilled nursing.

## Pharmacy Services

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Valley Health Plan (VHP) covers all drugs that are listed in the VHP Formulary that is maintained by the VHP Pharmacy and Therapeutics Committee.

VHP pharmacy benefit is managed by Navitus Health Solution. Navitus Customer Care is available 24/7 and can be reached at 1-866-333-2757.

Medically necessary non-formulary drugs may be covered by filling out an “Exception to Coverage (ETC)” form. (See Section 14 Forms & attachment). Forms can also be obtained using your NPI number through [www.navitus.com](http://www.navitus.com) or call Navitus at 1-866-333-2757. ETC form will be processed within 5 working days. Urgent ETC form will be processed within 72 hours. ETC form should be faxed to 920-735-5350.

All prescriptions must be filled at a VHP network pharmacy. In case of an emergency where a VHP network pharmacy is not available, members may fill the prescription at an out of network pharmacy.

If a Member uses an out of network pharmacy, the Member must pay the pharmacy directly and submit receipts for reimbursement to:

Navitus Health Solutions

Operations Division - Claims

P.O. Box 999 Appleton, WI 54912-0999

Dentist can prescribe only for antibiotics and pain medications. Optometrist can prescribe only for ophthalmic agents.

### Drug Formulary

To obtain a copy of the Drug Formulary call Provider Relations at (408) 885-2221.

### VHP Pharmacy Benefits and Authorization

Valley Health Plan uses a Formulary developed by Valley Health Plan Pharmacy and Therapeutics (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 physician in order to dispense the medication and receive payment.

When prior authorization is required for a drug, please contact Navitus at the above listed numbers.

## VHP NETWORK PHARMACIES

- **Safeway Pharmacies**
  - All U.S locations. For a list of locations visit [www.safeway.com](http://www.safeway.com)
- **Walgreens Pharmacies**
  - All U.S locations. For a list of locations visit [www.walgreens.com](http://www.walgreens.com)
- **Gardner Family Health Network**  
St. James Health Center  
55 E. Julian Street, San Jose  
Tel: 408-918-2600
- **Gardner Family Health Network**  
South County Health Center Pharmacy  
700 W. 6th Street, Suite F  
Gilroy, CA 95020  
Tel: 408-848-9400
- **Palo Alto Medical Foundation (PAMF)**  
Palo Alto Center Pharmacy  
795 El Camino Real  
Lower Level A, Lee Building  
Palo Alto, CA 94301  
Tel: 650-853-6066
- **Palo Alto Medical Foundation (PAMF)**  
Mountain View Center Pharmacy  
701 E. El Camino Real  
Mountain View, CA 94040  
Tel: 650-934-7699
- **Leiter's Compounding Pharmacy**  
1700 Park Avenue, Suite 30  
San Jose, CA 95126  
Tel:408-292-6772
- **Valley Specialty Center**  
751 S. Bascom Ave., San Jose  
Tel: 408-885-2310
- **Valley Health Center Bascom**  
750 S. Bascom Avenue, San Jose  
Tel: 408-885-2320
- **Valley Health Center East Valley**  
1993 McKee Road, San Jose  
Tel: 408-254-6340
- **Valley Health Center Gilroy**  
7475 Camino Arroyo, Gilroy  
Tel: 408-852-2297
- **Valley Health Center Lenzen**  
976 Lenzen Avenue  
San Jose, CA 95126  
Refill line: 408-792-5169
- **Valley Health Center Milpitas**  
143 North Main Street  
Tel: 408-957-0919
- **Valley Health Center Moorpark**  
2400 Moorpark Avenue, San Jose  
Tel: 408-885-7675
- **Valley Health Center Sunnyvale**  
660 S. Fair Oaks Avenue, Sunnyvale  
Tel: 408.992.4830
- **Valley Health Center Tully**  
500 Tully Road, San Jose  
Tel: 408-817-1360

Members are entitled to take certain health education classes at no charge. These classes are held at locations throughout Santa Clara County. Most classes are also available in Spanish and Vietnamese. Classes, sponsored by local agencies, include:

- Asthma
- Diabetes Management & Prevention
- First Aid/CPR
- Childbirth preparation

In addition, VHP offers wellness and health promotion classes to Members on:

- Yoga
- Tai Chi
- Zumba and
- Weight management.

Health Education provides classes and programs, health education materials and services.

For VHP Members, call VHP's Health Education Department at (408) 885-3490, e-mail [healtheducation@vhp.sccgov.org](mailto:healtheducation@vhp.sccgov.org) or visit our Web site [www.valleyhealthplan.org](http://www.valleyhealthplan.org) for a list of current classes.

For SCFHP Members, call Santa Clara Family Health Plan–Network 2 at 1-800-260-2055.

To refer Members to health education classes, please contact the Health Education Department directly.

The following information will be required:

- Member information (name, DOB, VHP ID# contact information)
- Physician contact information (phone and fax)
- Preferred Language
- Indicate class requesting for Member
- Any comments specific to Members' needs

### Health Education Materials

VHP providers may request selected materials free of charge. These materials have been reviewed for cultural & linguistic standards and are available in English, Spanish and Vietnamese. Topics include asthma, diabetes, domestic violence, smoking cessation, and health education. To obtain an order form and packet of sample materials, call (408) 885-3490 or e-mail [healtheducation@vhp.sccgov.org](mailto:healtheducation@vhp.sccgov.org)

To request materials on a specific topic, please contact the Health Education Department directly.

Studies show that patients learn the most from printed materials that are:

- Written in simple language and without medical jargon
- Formatted with plenty of white space
- Highlighted topic areas with easy-to-read headers
- Reflect the experiences of the intended audience in the text and illustrations
- Written in the primary language of the Member.

Health education evaluates patient education materials for reading level, content and layout, please fill out the Health Education Materials Readability Evaluation Form (see Section 15: Forms).



### **Tips for Teaching**

The following tips are useful when teaching a Member:

- Assess the Member's knowledge and readiness to learn.
- Start with basic information.
- Use everyday language.
- Speak clearly and position eyes at the Member's eye level.
- Demonstrate during explanation.
- Try to include family Members or a caregiver in the discussion.
- Use an interactive approach, i.e. let the Member participate actively in the discussion.
- Have the Member demonstrate understanding of material.

### **Effective Use of Educational Materials**

The following suggestions may help providers use educational materials more effectively:

- Preview the material.
- Use the material as a discussion tool.
- Personalize the material for the Member.
- Suggest ways the Member can use the material at home.

The Provider Relations Department is the primary point of contact for all providers. Its goal is to serve as a resource to all providers seeking information about network operations, credentialing providers, contracts interpretation and payment schedules.

**Section 12:** The staff conducts group and individual training sessions on the following topics:

- Provider Education
- Provider Disputes
- Access to Services
- Authorizations and Referrals
- Valley Express
- Legislative changes

Effective communication with providers is essential to improving overall satisfaction and services for our Members. Providers are encouraged to contact the Provider Relations Department with questions on policies, procedures, unresolved claims and general inquiries as well as to file any type of complaint or grievance. Providers may contact the Provider Relations Department during business hours at: (408) 885-2221.

Please visit our website at [www.valleyhealthplan.org](http://www.valleyhealthplan.org) to view the current version of the Drug Formulary, Clinical Practice & Referral Guidelines and Provider Manual, Updates and Bulletin's.

### Notification Requirements

To help Valley Health Plan maintain its directories, claims and payments records, it is important to notify the Provider Relations Department of any changes to your practice. Please notify the VHP in writing whenever a change in any of the following occurs:

- Name Change
- Billing address or practice location change
- Addition or deletion of clinic site
- New physicians or mid-level practitioners added or terminated from current practice
- Board certification or eligibility status change
- Privileges and licensure status
- Hospital affiliation
- Change in Tax Identification Number
- Professional malpractice or premise liability insurance changes
- Languages spoken in practice/Office hours
- Termination from employment

### Provider Disputes Process

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 establish timeframes and referring specific cases for peer review when needed.

### Provider Dispute Resolution Procedure and Process

It is the policy of VHP to establish an expeditious, fair and cost-effective 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. Upon receipt of a complete provider dispute, a letter of acknowledgement received by mail on paper will be sent within 15 working days and a resolution letter will be sent within 45 working days.

Use the following link to download the [Provider Dispute Form](#). 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 Process

Each provider dispute must contain at least the following information and be submitted on the form referenced below:

- a) Provider NPI;
- b) Provider TIN;
- c) Provider contact information, including provider name and complete mailing address;
- d) Member/patient name and member ID number;
- e) Member date of birth;
- f) Patient account number, if applicable;
- g) VHP claim number, date of service, original claim amount billed, and original claim amount paid;
- h) Dispute description, including any documentation supporting the dispute; and
- i) 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



## 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:**

<input type="checkbox"/> MD	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Hospital	<input type="checkbox"/> ASC	<input type="checkbox"/> SNF
<input type="checkbox"/> DME	<input type="checkbox"/> Rehab	<input type="checkbox"/> Home Health	<input type="checkbox"/> Ambulance	<input type="checkbox"/> Other: _____

**Dispute Type:**

<input type="checkbox"/> Claims	<input type="checkbox"/> Contract Dispute
<input type="checkbox"/> Underpayment/Overpayment/Timely Filing/EOB	
<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision (*Authorization reference)	
<input type="checkbox"/> *Authorization Number <input type="checkbox"/> 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:**

<input type="checkbox"/> Medical Records	<input type="checkbox"/> Authorization / Referral	<input type="checkbox"/> COB / EOB
<input type="checkbox"/> Proof of Timely Filing	<input type="checkbox"/> Proof of Eligibility	<input type="checkbox"/> AOR
<input type="checkbox"/> Other:	<input type="checkbox"/> Invoice / Bill	

**Expected Outcome:**

**Contact Information:**

\*Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_

\*Signature: \_\_\_\_\_ Date: \_\_\_\_\_ \*Fax Number: \_\_\_\_\_

\*Mailing Address: \_\_\_\_\_

## Provider Dispute Form – 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.

*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							

\*Provider Name: \_\_\_\_\_ NPI Number: \_\_\_\_\_  
 \*Provider Address: \_\_\_\_\_

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

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### Timeframe for Submitting an Initial Dispute

An initial appeal must be submitted within 365 calendar days of the date of notice of payment.

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

### 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 appeal 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 appeal by VHP.

If the provider initiates a dispute of a claim or requests reimbursement of the underpaid claim, the provider must also provide all required elements on the provider dispute form.

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 working days of the issuance of a written determination. 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.

Electronic:

VHP's claim system recognizes electronic claim submissions by the frequency code indicated on the claim. Please refer to 837 National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage of "claim frequency codes." All corrected electronic claim submissions should contain the original claim number or the Document Control Number (DCN).

Paper:

When submitting a paper claim, professional providers should use Form CMS-1500 (version 08/05) and institutional providers should use Form UB-04. Three Frequency codes for CMS-1500 Form box 22 (Resubmission Code) or UB-04 Form box 4 (Type of Bill) should contain a 7 to replace the frequency billing code (corrected or replacement claim), or an 8 (Void Billing Code). All corrected claim submissions should contain the original claim number or the DCN.

For the avoidance of doubt, a provider will only 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 non-participating provider's NPI specified in the provider's agreement with VHP to determine contract status for any particular lines of business or products offered by VHP.

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 working days of the issuance of a written determination.

### Claim Denial of Preauthorized Services

VHP provides a 30-day window from date of service for providers to request code changes if the preauthorized services do not match the services submitted on the claim. When a preauthorized service changes from what was planned during the course of the services being rendered, providers must submit clinical documentation to support the codes which the provider intends to bill on the corrected claim. These requests should be submitted to the Utilization Review Department at 408-885-7380.

### 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, quality of care, quality of service, access to care and to appeal any delayed, modified, or denied medical service or claim. VHP allows members to file grievances within 180 days following any incident or action that is the subject of the member's dissatisfaction.

**A provider, with the member's written consent, may file a grievance or appeal on behalf of the member.** For the provider to act as the member's representative, the member and provider must complete the Personal Representative Form (PRF) and submit the completed PRF along with the grievance or appeal.

# Authorized Representative Form

Located on the VHP website at

<https://www.valleyhealthplan.org/sites/m/mm/FormsResources/Documents/Authorized-Representative-Form-final-072020.pdf>



## Authorized Representative Form

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 act for you in most health care matters, and may use, receive, disclose your Protected Health Information.

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 return the completed form to **Attn: Member Services, Valley Health Plan, 2480 N. First Street Suite 160, San Jose, CA 95131**, or fax it to **1-408-885-4425**.

### 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 each box to acknowledge that you have read each condition.

<input type="checkbox"/> 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, wholly in my stead.
<input type="checkbox"/> 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.
<input type="checkbox"/> <b>This representative designation expires on (enter Month/Day/Year) _____</b> <b>(If no expiration date is provided, this appointment is in effect until revoked in writing).</b>
<input type="checkbox"/> I authorize VHP/DMHC to release any of my Personal Health Information and/or Identifiable Health Information to my appointed representative in order for her or him to act on my behalf and/or my child's behalf
<b>Or</b>
<input type="checkbox"/> This authorization is limited to: _____



**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: \_\_\_\_\_

Members may file a grievance or appeal 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 <https://www.valleyhealthplan.org/sites/m/mm/Grievances/Pages/GrievanceForm.aspx>.
3. Mail the grievance form to VHP’s Service Operations Department at 2480 N. First Street, Suite 180, San Jose, CA 95131.

## Member Grievance and Appeal Form

Located on the VHP website at <https://www.valleyhealthplan.org/sites/m/mm/FormsResources/Documents/Member-Grievance-and-Appeal-Form-final-072020.pdf>



### 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.*

For Internal Use Only	
Received by: _____	Date: _____
Date Member Notified Form Received: _____	
Date Member Acknowledgement Letter Sent: _____	
Case/Call Tracking Number: _____	<input type="checkbox"/> Appeal <input type="checkbox"/> Grievance

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.

### No Punitive Action Against a Provider

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

### Standard Review Process

Routine grievances will be acknowledged within five calendar days and will be resolved within 30 calendar days by VHP.

### Expedited Review Process

A member has the right to an expedited decision when the routine decision-making process for grievances 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 grievance.

### Department of Managed Health Care (DMHC)

Members have the right to contact the DMHC with a grievance. The member also has 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 DMHC can contact VHP 24 hours a day, seven days a week. Members can contact DMHC at (888) HMO-2219, TDD (877) 688-9891 for the hearing and speech impaired. Members may also access the DMHC website at [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov) for complaint forms, Independent Medical Review (IMR) application forms, and online instructions on how to file a grievance.

### **Provider Participation Requirements**

Valley Health Plan recruits and retains qualified physicians and providers. To accomplish this goal, all physicians and providers must submit a credentialing application and pass through the mandatory credentialing process.

### **Credentialing Application Process**

Valley Health Plan has adopted the California Participating Physician application form as its standard application. The Provider Relations Department is responsible for data maintenance, initial and subsequent evaluation and verification of provider credentialing applications. The findings of the Provider Relations Department are reviewed with the Medical Director and presented to the Credentialing Committee as recommendations. For the complete Credentialing policy and procedures, see Section 16.

### **Medical Record Confidentiality**

Access to medical records is permitted only to those individuals who are part of the team providing health care and must be secured per HIPAA privacy standards. Medical record information may be used by the plan or its providers only for a purpose directly connected with the performance of the Plans' obligations, including enforcement of the Provider's rights, quality management, or as otherwise required by applicable laws and regulations and in accordance with the terms of your Provider Services Agreement.

Medical records of all Valley Health Plan Members shall be kept confidential. Provider shall disclose protected health information only as necessary to provide medical care and review of medical care under the terms of the applicable program contract and as required in accordance with applicable laws and regulations.

The health plan and quality department are required to conduct regular Medical/Mental health provider audits as part of the oversight process. Mental Health records have the same requirements as those for physical medicine. Mental Health records contain psychotherapy notes.

The definition of psychotherapy notes are those notes recorded (in any medium) by a health care provider who is a Mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. It is the responsibility of the provider to separate the psychotherapy notes since they are not part of an oversight quality audit.

The following exclusions are part of the audit process and are elements found in the health plan's medical record audit tool. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

### **Medical Record and Facility Review**

The credentialing evaluation process may include an on-site Medical Record and Facility Review of the provider's primary office location(s) including an audit of a minimum of 5 active patient medical records. The tool used for conducting facility site audits and medical records audit is the current VHP QM/ACHS audit tool (subject to revision upon applicable laws and regulations).

The physical medicine audit will include the following: chart organization; preventive health; coordination/continuity of care; and facility standards review including physical accessibility, physical appearance, adequacy of waiting and examining room space, maintenance of confidentiality and availability of appointments, medical record keeping practices, including compliance with Health Insurance Portability and Accountability Act (HIPAA) for confidentiality

of records, security of Protected Health Information (PHI), Privacy notice, security of patients files both paper and electronic, storage and access to records. Similarly, the Mental health audit will include HIPAA privacy standards, procedures for urgent and emergent access, safe and appropriate office environment that meet regulatory standards, general medical record documentation (excluding psychotherapy notes), a thorough treatment plan, and progress notes for each visit.

To qualify for participation an evaluated provider must achieve an audit score of above 90% using the Criteria for Medical Record and Facility Review established by the NCQA. Providers whose audit results are below an 90% rating will be requested to submit a written Corrective Action Plan within 30 days and be re-audited within 30 days to six months to confirm a rating above 90%. Audit results are forwarded to the credentialing department as part of the provider's evaluation and credentialing process.

Site visits are performed by the Provider Relations Department if member complaints are received in the number or severity that meets the complaint threshold. Please see the Credentialing Policy in Section 16 for information on thresholds.

The Quality Management (QM) Program supports many of the activities of the Utilization Management, Provider Relations, Member Services, and Health Education Departments at Valley Health Plan. QM performs a number of ongoing and ad hoc quality and care review studies throughout the year. VHP's goal is to conform to regulatory standards set by the DMHC, the California Department of Health Services and all other regulatory agencies. The program closely monitors and promptly incorporates relevant statutory and regulatory changes. All providers must participate in the VHP QM program as part of the contractual agreement with VHP.

QM monitors and/or performs activities which may include the following:

- HEDIS (Health Plan Employer Data and Information Set)
- VHP also selects other clinical areas not covered by the HEDIS studies.
- Access Survey, Audit, Dashboard
- Audit of Primary Care Provider Sites and Medical Records
- Audit Behavioral Health Provider Sites and Medical Records
- Provider and Member Satisfaction Surveys
- Potential Quality Issues (PQIs)
- Provider Groups
- Contracted Hospitals

#### Goals and Objectives

- a) Design and maintain a QM structure and process that supports continuous quality improvement, including measurement, analysis, intervention, and reassessment.
- b) Pursue opportunities for improvements in the health status of the enrolled population through preventive care services, health education, and disease management.
- c) Establish clinical and service indicators (with appropriate performance goals and benchmarks) reflecting the demographic characteristics of the Membership.
- d) Annually measure Member satisfaction with providers and Plan through trending and analysis of the Member grievance process.
- e) Annually measure provider satisfaction and address sources of dissatisfaction.
- f) Develop priorities of focused studies, emphasizing high volume services and providers, high-risk populations, and other quality improvement areas.
- g) Ensure timeliness of Credentialing/ Re-credentialing of providers.
- h) Coordinate QM with performance monitoring activities throughout VHP.
- i) Develop an annual Work Plan that includes a schedule of activities with measurable objectives and monitoring of previously identified issues.
- j) Evaluate annually the effectiveness of the previous year's QM activities and interventions. Trend clinical and service indicators from year to year.
- k) Ensure provider performance in quality of care and service areas, medical record keeping, preventive health, accessibility of medical and behavioral healthcare, environmental safety, and health safety.
- l) Maintain and enforce a Conflict of Interest and Confidentiality policy for the protection of Peer Review activities and confidential Member and provider information.
- m) Ensure that the Health Plan does not exert undue economic pressure that might delay or withhold medically necessary services.

- n) Ensure Members' rights, dignity, and the total needs of each individual regardless of race, ethnicity, gender, religion, socioeconomic levels or sexual orientation.
- o) Ensure non-discriminatory evaluation of Member grievances or provider disputes.
- p) Promotes a setting in which all services are provided in a culturally linguistically appropriate manner.

QM attachments pertaining to the Quality Management Program, see Section 15.

### **Organizational Structure and Responsibility**

Governing Board: Health and Hospital Committee (HHC) is a subcommittee of the Santa Clara County Board of Supervisors formally empowered by the Board to serve as the governing board for VHP.

### **VHP Quality Management Committee**

The committee meets monthly or a minimum of four times per year to approve and oversee the implementation of the health plan's quality efforts and formalized program. The Medical Director or QMC Chairperson may call additional meetings if the need arises.

### **Annual QM Report**

The QM Committee provides an annual summary and evaluation of the effectiveness of the QM Program to the HHC. The HHC may approve the report and make recommendations and/or may make independent recommendations for action.

### **Medical Records Keeping**

All providers shall maintain medical records in accordance with standards established by VHP and regulatory agencies. Records must be maintained in a manner that is current, detailed, organized, permits effective patient care and quality review, and maintains confidentiality.

- a) The medical record is kept in a lockable file cabinet within the provider office and not accessible to patients.
- b) A system of medical record retrieval allows for prompt and accurate retrieval and availability to the provider at each patient encounter.
- c) The medical record system tracks the record when it is out of the filing system. There must be a system for the incorporation of information in the chart between visits as well as a system for the archiving of purged data.
- d) Medical records are inaccessible to patients and other unauthorized persons and are maintained to guard against unauthorized disclosure of confidential information and to protect confidentiality.
- e) There is a medical record for each Member seen.
- f) All pages in the record are securely anchored and all pages are filed chronologically.
- g) Each page in the record contains the patient's name or patient ID number for patient identification.
- h) Personal/biographical and demographic data include age, sex, address, telephone number, marital status, and are updated as appropriate.
- i) A copy of a "consent to treat" form is maintained in the medical record and other consents as required by current legislation.
- j) The medical record documents all aspects of patient care, including use of ancillary services.
- k) All entries are dated.
- l) The author of all entries is identified, including title.

- m) The records are legible, documented accurately, and in a timely manner.
- n) The reason for the visit is noted, i.e., the chief complaint(s).
- o) Diagnostic information and a plan of treatment for each visit are documented.
- p) Treatments, procedures, and tests, including results, are documented and consistent with treatment.
- q) There is a specific follow-up date for a return visit or other follow-up plan for each encounter.
- r) There is evidence of continuity and coordination of care between the primary and specialty physicians, including continuity of care and coordination between primary care and behavioral health providers.
- s) There is evidence that failed appointments are followed-up.
- t) As required by the Patient's Right to Self-Determination Act, documentation is present that the patient has executed an Advance Directive (a written instruction such as a living will or durable power of attorney for health care) or that information was offered /given to the patient.
- u) There is evidence of member health education, preventive care, and other health safety activities.



## HIPAA (Health Insurance Portability & Accountability Act)

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### Patient Confidentiality

Protecting the patients' privacy is an essential part of the physician/patient relationship. The most important issues that a physician needs to be aware of in doing business with Valley health Plan (VHP) are the following key points:

1. Providers are responsible for all of the Protected Health Information (PHI) created as the result of keeping records and billing for services. Any requests made to VHP by a patient to restrict or alter medical record information will be referred back to the provider's office.
2. Providers must use the appropriate codes for services and ensure that the treating provider is identified. Providers must ensure that all electronic or paper claims transmissions are secure and in the correct format.
3. Providers must give all of your patients the HIPAA privacy rules and their rights to requesting alterations or restrictions of their medical records
4. Providers must maintain a secure environment that protects PHI from an unauthorized person.
5. Provider's staff Members may only use only the PHI that is necessary to perform their job responsibilities.
6. Providers may transmit PHI to other parties without patient consent only for the purposes of treatment, payment, or operations (including regulatory reporting and compliance).
7. Providers may not release PHI to another party without the patient's authorization for purposes other than Treatment, Payment or Operations.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 addresses the efficiency and effectiveness of data exchange for administrative and financial transactions and the security and privacy of healthcare information. Among the key components of the regulations are: 1) Standards for Privacy of Individually Identifiable Health Information; 2) Transaction Codes and Identifiers; and 3) Security and Electronic Signature Standards.

HIPAA regulations require health plans, providers and healthcare clearinghouses to protect the privacy of patient information. To monitor compliance, VHP will review procedures and practices for confidentiality and medical record documentation as part of the site audits and Medical Records Review.

The Department of Health and Human Services is required to adopt "national uniform standards" for the following areas:

- a) Financial Transactions: includes claims and encounters, enrollment, claim status, insurance eligibility, referrals, and claim payment and remittance
- b) Code Sets: includes Diagnosis and Procedure coding (ICD9, CPT4, NDC, and HCPCS), involving disease, injuries, impairments, drugs, procedures, and billing
- c) Unique Identifiers: includes Individuals, Providers, Employers, and Health Plans
- d) Security: includes administrative security management procedures, physical access safeguards, technical security services and mechanisms, and electronic signature requirements
- e) Privacy and Health Information Disclosure: includes privacy protection practices and procedures to monitor release of information

### Financial Transactions

Providers are not required to submit claims electronically, but they are required to use the standard format for all claims submitted electronically. Payers, on the other hand, must have the capability to send and receive electronic transactions using the designated standards.

The Transaction standards for Health Care Claims or Equivalent Encounter Information, Coordination of Benefits, Enrollment/Dis-enrollment, Eligibility, Health Plan Premium Payments, and Referral Certification and Authorization includes:

### Code Sets

Local codes have been eliminated in the standard transactions. The standard code sets are:

- a) ICD-9-CM, Volumes 1 and 2 Diagnosis, and ICD-9-CM, Volume 3 for Procedures, to be used for all Inpatient Hospital Services, and applicable Outpatient Services
- b) The combination of HCPCS and CPT-4 for physician services and other health care services
- c) HCPCS for other substances, equipment, supplies, and other items used in health care services
- d) NDC for drugs and biologics
- e) The Code on Dental Procedures and Nomenclature for dental services

### Security

The proposed security requirements can be categorized in the following four areas:

- 1) Administrative Procedures – to guard data integrity, confidentiality, and availability. Documents formal practices to manage the selection and execution of security measures to protect data and the conduct of personnel in relation to the protection of data
- 2) Physical Safeguards – to provide physical protection of equipment and access to equipment control, including systems hardware, data storage devices, and secure workstation locations
- 3) Technical Security Services – these services include the processes that are put in place to protect, control, and monitor information access, including employee termination procedures, and unique user identification and authentication
- 4) Technical Security Mechanisms – to prevent unauthorized access to data that transmits over a communications network. Includes the processes that are put in place to prevent unauthorized access to data transmitted over the communications network, such as network and integrity controls, message authentication, and data encryption

### Privacy and Health Information Disclosure

Privacy regulations establish basic rights for patients who have protected health information. Regulations propose that individuals have a right to receive a written notice of information practices of the entity, and that they have a right to request and amend inaccurate or incomplete protected health information. The entity must provide a means for individuals to lodge complaints about the entity's information practices.

Covered entities must designate a privacy official, and develop a privacy training program for employees, implement safeguards to protect health information from misuse, and develop a system of sanctions for employees and business partners who violate the entity's policies and procedures.

## Language Assistance Program (LAP)

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It is the policy of Valley Health Plan (VHP) to continue to enhance and implement strategic plans that improve access and eliminate disparities in the quality of care for individuals with limited English proficiency or non-English speaking in Santa Clara County and to comply with SB853, Language Assistance Program (LAP) Regulations. As a County Health Plan, VHP is committed to identify these disparities and focus on reducing or eliminating them.

### Section 15:

#### The CA Language Assistance Program Law

Effective January 1, 2009 CA law (SB 853) and its accompanying regulations require that Health Plans establish and support a Language Assistance Program (LAP) for enrollees that are Limited English Proficient (LEP).

#### Who is eligible?

Enrollees under the jurisdiction of the Department Managed Health Care (DMHC) and/or California Department of Insurance (CDI) are eligible for the Language Assistance Program.

#### LAP STANDARDS

The key areas identified in the standards are:

- Collecting race, ethnicity, and language data
- Providing language services such as translation of written documents and oral interpretation
- Understanding of cultural differences relevant to the health care system
- Accountability and quality improvement
- Ensuring competency of translators in both English and target languages
- Competent in translating for health care terminology
- Interpreter ethics, conduct, confidentiality
- Reducing health care disparities

#### VHP LANGUAGE ASSISTANCE POLICIES AND PROCEDURES OVERVIEW

The LAP Policy and Procedure contains the following elements:

- All “points of contact” where the need for language assistance may be reasonably anticipated.
- The types of resources needed to provide effective language assistance to the Plan’s enrollees.
- Processes to ensure that LEP enrollees receive information regarding their rights to file a grievance and seek an independent medical review in threshold languages and through oral interpretation.
- Grievance forms and procedures in threshold languages are made readily available to enrollees and to contracting providers for distribution to enrollees upon request.

Processes for informing enrollees of the availability of language assistance services at no charge to them, and how to access language assistance services; these processes are those that:

- Promote effective identification of LEP enrollees language assistance needs at points of contact to ensure they are informed that interpretation services are available at no cost;
- Facilitate individual enrollee access to interpretation services at points of contact;
- Provide for the inclusion of the notice required with all “vital documents,” all enrollment materials and all correspondence, if any, from the Plan confirming a new or renewed enrollment. However, if documents are distributed in an LEP enrollee’s preferred written language the notice need not be included;

- Provide for the inclusion of statements in English and in the threshold languages in or with
- brochures, newsletters, marketing materials and other materials that are routinely disseminated to the Plan's enrollees that advise enrollees of the availability of free language assistance services and how to access them.

Processes to ensure that contracting providers are informed regarding the Plan's standards and mechanisms for providing language assistance services at no charge to enrollees, and to ensure that LEP language needs information collected by the Plan is made available to contracting providers.

Processes and standards for providing translation services, including:

- A list of the threshold languages identified by the Plan;
- A list of the types of standardized and enrollee-specific vital documents that must be translated and the applicable standards for making translated vital documents available to subscribers and enrollees;
- A requirement that non-English translations of vital documents must meet the same standards required for English language versions of those documents.

#### VHP THRESHOLD LANGUAGES ARE:

- English
- Spanish
- Vietnamese

#### HOW TO IDENTIFY A LEP ENROLLEE

- Enrollee self identifies as LEP by requesting language assistance
- Enrollee brings family member or friend to interpret for them
- Enrollee may have trouble communicating in English or you may have a very difficult time understanding what they are trying to communicate
- Enrollee simply says yes or no, or gives inappropriate or inconsistent answers to your questions
- Enrollee is quiet or does not respond to questions

#### UNDERSTANDING CULTURAL AND LINGUISTIC COMPETENCE OF LEP ENROLLEES

- Cultural and Linguistic Competence in Health Care- a set of similar behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.
- Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.
- Competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs

#### And why is it important?

Cultural competency is one the main factor in closing the disparities gap in health care. It's the way patients and doctors can come together and talk about health concerns without cultural differences hindering the conversation, but enhancing it. Quite simply, health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

Culture and language may influence:

- health, healing, and wellness belief systems;
- how illness, disease, and their causes are perceived; both by the patient/consumer and

- the behaviors of patients/consumers who are seeking health care and their attitudes toward health care providers;
- as well as the delivery of services by the provider who looks at the world through his or her own limited set of values, which can compromise access for patients from other cultures.

## REQUESTING TRANSLATIONS FOR VITAL DOCUMENTS

### Objective

Ensure Enrollees receive requested translations of non-standard vital documents in a timely manner, meeting the needs of the enrollee & regulatory standards.

### Requirement

- “VHP shall have up to, but not to exceed, 21 days to comply with the enrollee's request for a written translation in the threshold language.”
- Vital documents issued in English by the Plan will include a Notice of Translation in the Threshold Languages informing Enrollee of the availability of free language assistance that will be provided by the Health Plan.
- If the Enrollee’s preferred language is one of the threshold languages, they may also receive a written translation of the vital document.
- If the Enrollee requires help, the Notice instructs them to call the Plan’s number or a toll- free number provided on the Notice.
- Translation requests will normally come through the Health Plan, but may be received by
- Providers.
- If translation request is for a Provider-produced letter, the Provider will need to submit a copy of that letter to the Plan in a timely manner.

## LAP NOTICE OF TRANSLATION

### English

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1(888) 421-8444 OR (408) 885-4760

### Spanish

IMPORTANTE: ¿Puede leer esta carta? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta carta escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al 1(888) 421-8444 O (408) 885-4760

### Vietnamese

QUAN TRỌNG: Quý vị có đọc được lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận thư này bằng tiếng Việt. Để được giúp đỡ miễn phí, xin gọi ngay số (888) 421-8444 “HOẶC” (408) 885-4760

## HOW TO ACCESS INTERPRETERS

### ORAL INTERPRETATION

Each department and physician office shall be provided with a five-digit Identification Number (this shall be communicated by VHP’s Provider Relations Department).

- The five-digit Identification Number shall be recorded and maintained by the Provider
- Relations Department, and communicated to the Director of Language Services.
- The purpose of this Identification Number is twofold:
  - to prevent unauthorized users from accessing services, and

- to allow for tracking of usage.
- All departments and provider's offices shall contact the Language Services Department by dialing (408) 278-9927.
- Upon dialing this number they shall be asked to input their five-digit code. Once the five-digit code has been successfully entered, they will be prompted to select Spanish or any other language need, and the call shall route to the appropriate work unit.

#### **TIPS FOR WORKING WITH INTERPRETERS**

- Speak at an even pace in relatively short segments; pause often to allow the interpreter to interpret.
- Ask one question at a time.
- Acknowledge the interpreter as a professional in communication.
- Hearing impaired should contact CA Relay Services; the Health Plan will assist them in accessing Language Services.

#### **WRITTEN TRANSLATION**

The Language Services Department may be utilized as a resource for the translation of vital documents; contracted VHP physician offices and internal VHP departments may request translation of vital documents by sending an email (along with the document to be translated) to the Language Services Department at the following address: [hhslanguageservices@hhs.sccgov.org](mailto:hhslanguageservices@hhs.sccgov.org)

## Glossary of Terms

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**Ancillary Services Health** care services conducted by providers other than primary care physicians such as home health services, durable medical equipment, skilled nursing care.

**Authorization** means a written approval by a Medical Director or his/her designee for a Member to receive certain Medically Necessary Covered Services before services are rendered.

**Agreement** means the Group Service Agreement, including but not limited to this Combined Evidence of Coverage and Disclosure Form, any and all applications and information submitted by the Group and Members in applying for Coverage, attachments, addenda, and any amendments that may be added in the future. The Agreement contains the exact terms and conditions of Coverage. It incorporates all of the contracts, promises, and agreements exchanged by the Group and VHP. It replaces any and all prior or concurrent negotiations, agreements, or communications, whether written or oral, between both parties with respect to the contents of the Agreement.

**Covered Services** means the Medically Necessary health care services, supplies and products modified by the exclusions and limitations to which you are entitled as a Member under your Group Service Agreement and which are described in this Combined Evidence of Coverage and Disclosure Form.

**Benefit Plan** means the Covered Services contained in this Combined Evidence of Coverage and Disclosure Form. Any date referenced in this Benefit Plan begins at 12:01 a.m., Pacific Standard Time.

**Benefit Year** means a period of the twelve (12) months commencing with the effective or anniversary date of the Agreement.

**Capitation** A method of payment in managed care in which a provider is paid a fixed amount per person enrolled in a plan. This fee is based on a defined set of benefits and is typically paid on a monthly basis regardless of the type of care delivered or the frequency with which a patient accesses services.

**CCS (California Children's Services)** The CCS program, administered by the state and counties, provides medical care for eligible low-income families with children who have serious medical problems. These include acute injury and illness, genetic diseases, chronic conditions or physical disabilities, congenital defects, and major injuries due to violence and accidents. CCS covers medical services including physician services, hospital care, laboratory work, X-rays, rehabilitation services, pharmaceuticals, durable medical equipment and case management.

**CHDP (Child Health Disability Prevention Program)** administered by the state and counties, provides preventive health screening examinations to children with family incomes of less than 200% of the federal poverty level.

**Claim** is a demand to the insurer by or on behalf of a Member for the payment of benefits under a policy.

**Coordination of Benefits (COB)** applies when a Member is covered by two (2) or more insurance plans, COB: eliminates duplicate payments, specifies the order in which coverage will be paid (the primary plan, the secondary plan, etc.), and ensures that the benefits paid under both plans do not total over 100% of the charges.

**Co-payment** is a fee, which a Member is required to pay in order to receive a particular Benefit. Co-payments paid for eyeglasses, Dental Services, or any other supplementary benefit(s) that are not covered under this Benefit Plan are not counted against the Co-payment Maximum.

**Co-payment Maximum** is the maximum Member responsibility for Covered Services during a Benefit Year.

**Cosmetic Surgery** is performed to alter or reshape normal structures of the body in order to improve appearance.

**Coverage Decision** means the approval or denial of Covered Services by VHP.

**Department of Managed Health Care (DMHC)** is the State regulatory agency responsible for the regulation or oversight of health maintenance organizations in California.

**Disenrollment** is the process of ending Membership from the health care plan.

**Durable Medical Equipment (DME)** means the Medically Necessary medical supplies, equipment, and devices which:

- are intended for repeated use over a prolonged period,
- are not considered disposable, with the exception of ostomy bags and diabetic supplies,
- are ordered by a Plan Physician,
- do not duplicate the function of another piece of equipment or device covered by VHP,
- are generally not useful to the Member in the absence of illness or injury,
- primarily serve a medical purpose, and
- are appropriate for use in the home.

**Emergency Services**, as set forth in Title 22, California Code of Regulations (“CCR”), section 51056, and California Health and Safety Code section 1317.1, means those services required for alleviation of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- placing the patient’s health (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

**Emergency Services** also includes screenings, examinations, and evaluations for the purpose of determining whether a psychiatric emergency condition exists, and for which treatment is necessary to relieve or eliminate the psychiatric emergency condition.

**Eligibility Verification** is the process by which a provider confirms an enrollee’s Membership status with the health plan.

**Experimental or Investigational Treatment** means services, tests, treatments, supplies, devices or drugs which the Plan determines is not generally accepted by medical professionals in the United States, at the time services, tests, treatments, supplies, devices or drugs are rendered, as safe and effective in treating or diagnosing the condition for which their use is proposed, unless approved by:

- The Diagnostic and Therapeutic Technology Assessment Project of the American Medical Association;
- The Office of Technology assessment of the U.S. Congress;
- The National Institute of Health;
- The Food and Drug Administration (FDA); or
- The specialty board and the academy it represents as recognized by the American Board of Medical Specialties (ABMS).

Approved drug usage will not be excluded as an Experimental or Investigational treatment.

**Fee for Service** is a payment method based on each visit or service rendered.



**Formulary** is the list of prescription drugs that has been reviewed and selected by VHP in accordance with professionally-recognized medical standards for their medical and cost effectiveness. The Formulary includes both brand name and generic drugs, all of which are approved by the Food and Drug Administration (FDA).

**Grievance** The process for resolving a complaint by a Member or the process to have a decision reviewed involving the denial of a service (in whole or in part).

**Infertility Treatment** means procedures consistent with established medical practices by licensed physicians and surgeons including, but not limited to, diagnosis, diagnostic tests, medications and any medically necessary surgery.

**Healthy Families California Program Children’s Health Insurance Program (CHIP)** provides coverage to children in families with incomes between 100% and 200% of the federal poverty level.

**Healthy Kids Santa Clara County Program Santa Clara County Insurance Program** funded by the Tobacco Settlement Funds provides coverage to any child in a family with incomes at 300% of the federal poverty level.

**HMO (Health Maintenance Organization)** A health plan that delivers and manages the provision of health services under an agreement with a payer. The HMO is usually paid a monthly premium for each person enrolled in the plan regardless of the frequency or type of service provided.

**Limited English Proficient (LEP)** – An enrollee who has an inability or a limited ability to speak, read, write, or understand the English language at a level that permits that individual to interact effectively with health care providers or Plan employees.

**Medical Director** is a physician responsible for medical administration and authorization of care. The Plan Medical Directors manage utilization and quality of health care.

**Medi-Cal Managed Care–Network 2** One of the networks within Santa Clara Family Health Plan. This network includes the physicians and providers at VMC, Gardner Family Health Network, Planned Parenthood, Mayview Community Clinic, Indian Health Clinic, School Health Clinics, East Valley Community Clinic, AACI Community Clinic, Valley Health Centers, and Lucille Packard Children’s Hospital.

**Medically Necessary or Medical Necessity** are:

- appropriate for the symptoms, diagnosis, or treatment of a medical condition, and
- within recognized standards of medical practice, and
- not primarily for the convenience of the Member, the Member’s family, caretaker, or any provider, and
- the most appropriate supply or level of service that can safely be provided.

**Network** is a health care delivery service system that is contracted and credentialed within the Service Area. The Network is comprised of Plan Physicians (such as Primary Care Physicians and Specialists), Plan Facilities, and Plan Hospitals.

**Network 2** One of the networks within Santa Clara Family Health Plan. This network includes the physicians and providers at VMC, Gardner Family Health Network, Planned Parenthood, Mayview Community Clinic, Indian Health Clinic, School Health Clinics, East Valley Community Clinic, AACI Community Clinic, Valley Health Centers, and Lucille Packard Children’s Hospital.

**Non-Formulary Drug** Drugs that are not covered under the SCVHHS Formulary. Non-formulary drugs may be requested through the Medical Director.

**Out of Network** Any provider who does not contract with VHP.

**Plan** or **VHP** means Valley Health Plan. The County of Santa Clara owns and operates VHP, which is licensed under the Knox-Keene Health Care Service Plan Act.

**Plan Facility** means a facility (other than a Plan Hospital), such as a Skilled Nursing Facility or Mental health hospital that contracts with VHP to provide Medical Services.

**Plan Hospital** means Santa Clara Valley Medical Center or any other duly licensed hospital that, at the time care is provided, has a contract with VHP to provide Hospital Services.

**Plan Pharmacy** means a Santa Clara Valley Health and Hospital System pharmacy that provides medication(s) prescribed by Plan Providers.

**Plan Physician** is a duly licensed physician or physician group that, at the time of care is provided, is contracted with VHP to deliver health care services.

**Plan Provider** means any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the State to deliver health care services that, at the time care is provided, is contracted with VHP to deliver services.

**Plan Specialist** means a physician who practices in a medical specialty and contracts with VHP to deliver health care services.

**Points of Contact** – An instance in which an enrollee accesses the services covered under the Plan contract, including administrative and clinical services, and telephonic and in-person contacts.

**Primary Care Physician (PCP)** means a Plan Physician who has contracted with VHP to deliver primary care services to Members. A Primary Care Physician is trained to take care of routine health care needs and is primarily responsible for the coordination of care. Coordinating care includes supervising continuity of care, record keeping, and initiating referrals to Specialists. Primary Care Physicians can be family or general practitioners, pediatricians, or internists. In addition, obstetricians/gynecologists (OB/GYNs) may serve as Primary Care Physicians if they meet VHP criteria for the delivery of primary care.

**Provider Bulletin** is a quarterly publication specific to VHP providers regarding updates in VHP operations or legislation that may affect the Plan.

**Rehabilitation Services** means a prescribed, organized, multidisciplinary rehabilitation program, whether in a hospital, Skilled Nursing Facility, physician's office or other facility.

**Reconstructive Surgery** means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function, or to create a normal appearance, to the extent possible.

**Routine Care** means the provision of Medically Necessary services required for:

- screening purposes and disease prevention
- the diagnosis and treatment of new or ongoing illnesses or injuries, or
- the evaluation and treatment of signs or symptoms which a prudent lay-person or physician might reasonably be concerned to represent a deterioration in health status. Routine Care is not for an immediate risk requiring either urgent or emergency care.

**Referral Center** SCVMC's processing center for all specialty referrals.

**Service Area** means Santa Clara County. The Department of Managed Health Care (DMHC) has licensed VHP to provide health care services to Members who live or work within Santa Clara County.

**Service Agreement** The contract between VHP and providers to render health care services to Members.

**Standing Referral** means a referral to a specialist for more than one visit as indicated in the treatment plan, without the PCP having to provide a specific referral for each visit.

**Threshold Languages** are identified by the Health Plan and are the languages that vital documents shall be translated. A health care service plan with less than 300,000 shall translate vital documents into a language other than English when the language spoke encompasses, 3,000 or more or 5 percent of the enrollee population, whichever is less.

**Urgently Needed Services** means the Covered Services for an illness or injury which, if left untreated for a period in excess of 48 hours, in the view of a prudent lay-person or physician, is likely to lead to a serious deterioration in the Member's health or significant disability.

**Valley Health Plan Commercial Health** is an insurance Plan that provides health care services to enrollees who are employees of the County of Santa Clara or other nonprofit agencies.

## Section 17: Forms and Attachments

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The following forms are included in this section. You may copy them as needed or visit the “For Providers” section of the Valley Health Plan website at [www.valleyhealthplan.org](http://www.valleyhealthplan.org)

- Sample - Valley Health Plan Commercial I.D. Card
- Treatment Authorization Request (TAR) Form for Services Outside of SCVMC
  - Instructions for Completing a TAR Form
- Mental Health Re-authorization Request Form
- Credentialing and Re-Credentialing Policy and Procedures
- Pediatric Preventive Primary Care Guidelines
  - Immunization Schedules
    - Adolescent
    - Pediatric
    - Pediatric Catch-up
    - Vitamin D
- Adult Preventive Primary Care Guidelines
- Clinical Practice & Referral Guidelines
  - Content page and current list
- VHP/SCVHHS Non-Formulary Drug Request Form – For most current form, please contact Provider Relations at 408.885.2221.
- Providers’ Guide to Blood Pressure Tele-monitoring with BPLink – For most current form, please contact Provider Relations at 408.885.2221.

# Front

**VHP**  
Valley Health Plan

Employer Group Plan 2020

Member Name	DOB	Gender
Jennifer T. Doe	12/12/12	F
Identification #	Plan	
31234456811	Classic Plan	
Network	<b>SAMPLE</b>	
SCVMC		
Primary Care Physician (PCP)		
John Smith, M.D		

RxGroup# VHPA RxBIN# 610602 RxPCN# NVT

# Back

This card is issued to VHP Member for identification purposes only. The provisions of health plan benefits are subject to the terms and conditions of the Service Agreement. For eligibility and benefits information, or for Primary Care Physician (PCP) or Mental Health appointment phone numbers and information, please visit [www.valleyhealthplan.org](http://www.valleyhealthplan.org) or call VHP Member Services.

Members:

VHP Member Services ..... 1.888.421.8444 (toll-free)  
24/7 Nurse Advice Line ..... 1.866.682.9492 (toll-free)  
Navitus Customer Care ..... 1.866.333.2757 (toll-free)  
MDLIVE Telehealth ..... 1.888.467.4614 (toll-free)

Pharmacists & Providers:

Navitus Customer Care ..... 1.866.333.2757 (toll-free)

Submit medical claims to:

VHP Claims Department, P.O. Box 26160, San Jose, CA 95159

Call 911 in the case of an emergency.

If admitted to a hospital, a provider must call 1.855.254.8264.

**SAMPLE**

# Valley Health Plan Member ID Card – Sample



## AUTHORIZATION REQUEST

Instructions: This form is required for authorization of services. Please complete all the **unshaded** sections on this form and fax to the Utilization Management Department at Valley Health Plan.

Fax #: 408.885.4875  
Phone #: 408.885.4647

### Section 2:

#### Location of Authorization

- Inpatient       Outpatient  
 Other \_\_\_\_\_

#### Request Type (Check One)

- Emergency       Routine  
 Urgent           Retro

#### Program/Line of Business (Check One)

- Employer Group Plan       SCFHP Medi-Cal  
 Covered CA/Individual & Family       SCFHP HK

### Section 1:

#### Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex (check one):  Female  
 Male

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ VMC Medical Record #: \_\_\_\_\_

Health Plan ID#: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD10 Code: \_\_\_\_\_

#### Requested Provider

Provider Name: \_\_\_\_\_

Location: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Services and Provider Requested

#### Section 3:

*Attach supporting documents such as progress notes, consultation notes, operative/radiological reports, and/or prescriptions to avoid delay in processing request*

CPT4 or HCPC	Quantity	Length of Need	Specific Services Requested
1.			
Medical Justification for Request			
2.			
Medical Justification for Request			
3.			
Medical Justification for Request			
4.			
Medical Justification for Request			

### Section 4

Requesting Provider: \_\_\_\_\_ MD Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE TO ALL PROVIDERS:** This authorization is valid only if the patient is eligible on the date of service. Please recheck eligibility prior to delivering service (VHP Commercial patients: 408.885.4760 or 1.888.421.8444 – Medi-Cal Managed Care, Healthy Kids & Healthy Families patients: 1.800.260.2055).



## AUTHORIZATION REQUEST

### Instructions for Completing the Authorization Form

Field Name	Description
<b>SECTION 1 – This section is completed by the <u>requesting physician</u> to provide information about the patient</b>	
Patient Name	Enter the patient's name (first name followed by last name) for whom services are requested
Date of Birth	Enter the patient's date of birth
Sex	Check the appropriate box for the patient's gender
Address	Enter the patient's current address
Phone	Enter the patient's current phone number
VMC Medical Record #	Enter the patient's Medi-Cal number, VMC number, or Social Security number (if Commercial).
Health Plan ID #	
Diagnosis.	Enter the patient's diagnosis or ICD10 Code.
ICD10 Code	
<b>Section 2 – This section is completed by the <u>requesting physician</u> to provide information about the services ordered for the patient.</b>	
Location	Check the appropriate box for the location of the services: INPATIENT, OUTPATIENT, OTHER (Please specify)
Type Service	Check the appropriate box for the type of service required: EMERGENCY, URGENT, ROUTINE, or RETROSPECTIVE.
Program/Line of Business	Check the type of program in which the member is enrolled: Employer Group, Covered CA/Individual & Family, SCFHP Medi-Cal, SCFHP HK.
Requested Provider	Enter the information (Name, Location, Phone #, and Fax #) of the requested provider that the referring physician is recommending
<b>Section 3 – This section is completed by the <u>requesting physician</u> to indicate the services required.</b>	
CPT4 or HCPC	Enter the appropriate CPT4 or HCPC code for the procedure requested
Quantity	Enter the number of procedures/treatments requested
Length of Need	Enter the amount of time the procedure/treatment is required
Specific Services Requested	Enter the specific information regarding the services required
Medical Justification for Request	Enter the medical information to indicate the need for the procedure/treatment
<b>Section 4 – This section is completed by the <u>requesting provider</u>.</b>	
Requesting Provider	Print the name of the requesting provider
Signature	The requesting provider must sign the treatment authorization request.
Date	Indicate the date when the requesting provider signs the request.

**BEHAVIORAL HEALTH TREATMENT PLAN RE-AUTHORIZATION REQUEST**

Name \_\_\_\_\_ of \_\_\_\_\_ Member: \_\_\_\_\_  
 Member \_\_\_\_\_ Plan Number: \_\_\_\_\_  
 Treatment \_\_\_\_\_ Provider: \_\_\_\_\_  
 DSM IV Diagnosis: \_\_\_\_\_  
 Current Symptoms: \_\_\_\_\_

Speech:  Normal  Pressured  Evidence of Blocking  
 Mood/Affect:  Euthymic  Depressed  Dysphoric  Euphoric  Despondent  Angry  
 Anxious  Fearful  Hopeless  Helpless  Crying Spells  
 Range:  Normal  Restricted  Blunted  Flat  Labile  Inappropriate to Content  
 Thought Process:  Goal Directed  Tangential  Blocking  Loose Associations  
 Flight of Ideas  Racing Thoughts  Concrete  
 Thought Content:  Suicidal  Phobias  Homicidal  Hallucinations  
 Auditory  Obsessions  Visual  Command  
 Harm to Others  Self  Delusions Type:  Other: \_\_\_\_\_

Harm/Mutilation \_\_\_\_\_  
 Cognitive Impairment:  Memory  Concentration  Insight  Digit Span  
 Comprehension  Judgment  Level of Consciousness  Orientation: \_\_\_\_\_

Pertinent stressors: \_\_\_\_\_

Goal of Treatment: \_\_\_\_\_

Treatment requested:  Individual Therapy  Couples Therapy  Family Therapy  
 Group Therapy  Medication Management  Other (specify): \_\_\_\_\_

At frequency of: \_\_\_\_\_

Please briefly note issues, which have prevented client from attaining treatment goals (compliance, resistance, newly identified stressors, etc.) and indicated adjustment to treatment plan (attach second sheet if needed):

Additional factors for consideration (attach second sheet if needed):

Request for authorization for the following dates: From \_\_\_\_\_ To: \_\_\_\_\_

Signature/Date: \_\_\_\_\_



## 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:	<input type="checkbox"/> Male <input type="checkbox"/> 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:				
<input type="checkbox"/> New Therapy <input type="checkbox"/> Renewal <input type="checkbox"/> Step Therapy Exception Request If Renewal: Date Therapy Initiated: _____ Duration of Therapy (specific dates): _____				
How did the patient receive the medication?				
<input type="checkbox"/> Paid under Insurance Name: _____ Prior Auth Number (if known): _____ <input type="checkbox"/> Other (explain): _____				
Dose/Strength:		Frequency:	Length of Therapy/#Refills:	Quantity:
Administration:				
<input type="checkbox"/> Oral/SL <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Other: _____				
Administration Location:		<input type="checkbox"/> Patient's Home <input type="checkbox"/> Long Term Care <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Other (explain): _____ <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Outpatient Hospital Care _____		

## PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Patient Name:	ID#:
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**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.

<b>1. Has the patient tried any other medications for this condition?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>Medication/Therapy</b> (Specify Drug Name and Dosage)	<b>Duration of Therapy</b> (Specify Dates)	<b>Response/Reason for Failure/Allergy</b>
<b>2. List Diagnoses:</b>		<b>ICD-10:</b>
<b>3. <u>Required clinical information</u> - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.</b>		
<p>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.</p> <p><input type="checkbox"/> Attachments</p>		

**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: \_\_\_\_\_

**Access Formularies via our Provider Portal [www.navitus.com](http://www.navitus.com) > Providers > Prescribers Login**



# Policy and Procedures Operating Manual

**Section Name:** Provider Relations  
**Section Number:** 7000  
**Product:** Commercial

<b>POLICY NUMBER: COM 7100</b>		<b>SUBJECT: VHP(PLAN)/ SANTA CLARA VALLEY MEDICAL CENTER (GROUP)CREDENTIALING &amp; RE-CREDENTIALING</b>		
EFFECTIVE / REVISION	DATE	REVISION #	APPROVED BY VHP COMPLIANCE	DATE
Effective Date	12/2/96	0		
Revision Date	12/17/08	8		
Revision Date	12/17/09	9		
Revision Date	12/22/10	1		
Revision Date	12/21/11	1		
Revision Date	6/28/13	1		
Revision Date				
APPROVALS	DATES	SIGNATURE		
Manager Approval	12/2011; 6/28/13	On File		
Credentialing Committee	12/2/96; 5/19/97; 8/23/00; 9/5/02; 4/21/03; 10/19/05; 12/20/06; 8/15/07; 12/17/08; 12/17/09; 12/22/10;			
QM Committee	7/8/13			

## I. PURPOSE:

The County of Santa Clara dba Santa Clara Valley Medical Center (Group) and Valley Health Plan’s (Plan) credentialing policy establishes the procedures for evaluating and determining a practitioners acceptance for initial and continued participation in the Plan/Group. Through this policy, the Plan ensures that participating providers meet basic qualifications before delivering care to Members and re-verifies the qualifications of participating providers on an every three-year (36-months) basis. The Plan also acts as the Management Services Organization for Santa Clara Valley Medical Center to credential and re-credential practitioners for the health plans that the Group contracts with. The credentialing/re-credentialing policy is one aspect of the Plan/Group Quality Improvement Program.

# COM 7100\_VHP/SCVMC (GROUP) CREDENTIALING AND RE-CREDENTIALING

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## II. APPLICABILITY:

This policy governs the credentialing/re-credentialing and monitoring of: Physicians (M.D.), Dentists (DDS), Oral Surgeons, (DMD), Podiatrists (DPM), Doctors of Osteopathy (D.O.), Nurse Practitioners (N.P.), Certified Registered Nurse Anesthetist (C.R.N.A), Physician Assistants (P.A.), Certified Nurse Mid-Wife (CNM), Chiropractors (D.C.), Doctors of Optometry (O.D.), Clinical Psychologists (Ph.D.), Behavioral Health Practitioners [Such as, Marriage Family Therapists (MFT), Marriage Family and Child Counselors (MFCC), Licensed Clinical Social Workers (LCSW)] and Ancillary practitioners.

## III. POLICY:

### *A) INTRODUCTION*

It is the Plan/Group's policy to make every reasonable effort to ensure that the health care practitioners who participate in the Plan/Group undergo a credentialing process. The process involves a completion of a Participating Practitioner Application, primary source verification, medical malpractice review, and approval by the Credentialing Committee and/or Medical Director before the practitioner can be listed as a Plan/Group practitioner in the Provider Directory.

The credentialing process will be performed in an objective, non-discriminatory and unbiased manner. No practitioner shall be denied an agreement with the Plan, have any sanctions imposed, or have their agreement terminated on the basis of age, race, creed, color, national origin, sexual orientation, sex/gender, ancestry, mental/physical disability, medical condition, political beliefs, organization affiliations, marital status, or based on type of procedures or patient (e.g. Medi-Cal) in which the practitioner specializes. An annual audit is performed by the VHP Quality Manager of practitioners denied for participation for reasons not related to failing to complete the credentialing/re-credentialing process to ensure discriminatory practices are not conducted. The results of the audit will be reported to the Credentialing Committee and the Quality Management Committee.

### *B) RESPONSIBILITIES*

The Santa Clara County Board of Supervisors, through the Health and Hospital Committee (HHC), is ultimately responsible for the quality of care delivered to Plan/Group members. The HHC has the ultimate authority to approve/disapprove credentialing/re-credentialing decisions and to delegate roles and responsibilities for the process to the following bodies:

- 1) Quality Management Committee (QMC)
- 2) Credentialing Committee (CC)
- 3) Provider Relations Specialist/Credentialing Specialist
- 4) Medical Director or his/her designee

## COM 7100\_VHP/ SCVMC (GROUP) CREDENTIALING AND RE-CREDENTIALING

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The responsibilities of the respective delegated bodies are as follows: The QMC is responsible and accountable for the continuous quality of care and service for all Plan/Group members. Quality management involves assessment and establishing goals for improvement and evaluation of the process. The QMC makes determinations on practitioner issues, reviews activities, reports, and makes recommendations to the HHC.

The CC is a multidisciplinary team of physicians that monitors and reviews the quality of care findings from credentialing and audit activities of the UM/QM Management and Credentialing Specialist. This Committee makes determinations and hears practitioner appeals regarding initial and subsequent credentialing decisions based on clinical competency and/or professional conduct. The Committee members are required to sign a statement that affirms that members will not discriminate and will maintain confidentiality during the credentialing/re-credentialing process and/or meeting. The CC reports credentialing action items to the QMC on at least a quarterly basis.

- 1) Membership: The Credentialing Committee shall consist of at least three participating physicians representing a cross section of surgical and medical specialties, including primary care. The CC will maintain a list of practitioners in specialties not represented on the committee to advise the Medical Director, or designee, on applicants with adverse information that may require specialty review. The CC meets at a minimum of six times per year. Meetings may be held either in person or through teleconferencing.
- 2) Quorum: A quorum consists of one-half of the voting members of the committee, but in no event less than two voting physician members, including the Committee Chairperson. Only physicians can be voting members. The Medical Director and his/her designee serve as Chair to the Committee.
- 3) Committee Records: The Committee maintains a permanent and confidential record of its proceedings, of the persons attending each meeting, and the results of the vote on each matter upon which a vote is taken.
- 4) Routine Committee Meetings: All credentials presented to the Credentialing Committee for review must be updated and the attestation questionnaire and release of information page must be signed within a minimum of 180 days prior to the Credentialing Committee meeting. Applicants for credentialing/re-credentialing are brought to committee.

The **Medical Director** is responsible for professional medical oversight of the activities of the Provider Relations Department, CC, and QMC. The Medical Director, or his/her designee, serves as Chair for QMC and CC. The Medical Director, or his/her designee makes final recommendations regarding practitioner participation and/or appeals regarding credentialing decisions based on clinical competency and/or professional conduct. The Medical Director and/or his/her designee have the authority to approve a “clean file” outside of the Credentialing

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Committee as needed. In addition, the Credentialing Policy is reviewed annually by the Medical Director and/or his/her designee and the Credentialing Committee for possible updates and/or revisions.

The ***Provider Relations Manager*** is responsible for implementation of the credentialing policy and procedures. The Provider Relations (PR) Specialist and/or Credentialing Specialist reviews and evaluates the qualifications of each practitioner applying to become a participating practitioner or seeking continued participation with the Plan/Group and documents relative findings to the Medical Director and/or his/her designee for presentation to the CC. Following any decision of the CC, the PR Specialist carries out necessary actions and notification regarding practitioner participation status. The PR Specialist and the Credentialing Specialist is trained, at time of new hire orientation, using the National Committee for Quality Assurance (NCQA) and/or Industry Collaboration Effort (I.C.E). Site Audit tool to perform practitioner office site visits as a result of a member complaint, in accordance with Office Site Visit Process.

## IV. CREDENTIALING PROCESS

### ***A) APPLICATION PROCESS FOR INITIAL CREDENTIALING & RE-CREDENTIALING***

The Provider Relations Staff is notified of interested applicants from a number of sources. To initiate the process the practitioner is sent a credentialing application along with a list of needed documents (Attachment A) and an Adverse Action Memorandum and Practitioner Rights document (Attachments A checklist).

The Credentialing/Re-credentialing application is developed for submission by specific practitioners as follows:

- 1) California Participating Provider Application and Addendum, or other health plan approved Application, are required for participation of all physicians, podiatrists and mid-level practitioners with the exception of hospital-based physicians, i.e., emergency medicine, radiology, pathology, anesthesiology, neonatology, hospitalists and locum tenens (providing services in patient care areas for less than 90 days).
- 2) Participating Ancillary Practitioner Application is required for Medical Transportation, Free Standing Laboratory and Radiology Facilities, Optometry, Optical, Eye Appliance, Pharmacy, Physical Therapy, Occupational Therapy, Speech Pathology, Audiology, Home Health, Chiropractic, Acupuncture, Durable Medical Equipment, Medical Supplies, Orthotics, Prosthetics, and Hearing Aid practitioners.

## COM 7100\_VHP/SCVMC (GROUP) CREDENTIALING AND RE-CREDENTIALING

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### ***B) MINIMUM QUALIFICATIONS FOR PRACTITIONER PARTICIPATION***

A Practitioner must meet the following minimum qualifications:

- 1) Practitioner must supply a completed/signed application and attestation questionnaire attesting to the correctness and completeness of information included in the application, and provide all requested attachments, which are part of the application. In addition, a copy of a current Curriculum Vitae or complete work history must be included with the application packet. The attestation questionnaire includes:
  - a. A minimum of five years work history for new practitioners. Gaps of six months or longer are
  - b. researched and explanation is required of a practitioner and documented in the file by practitioner
  - c. or credentialing staff. Gaps of one year or longer must be explained by the applicant in writing.
  - d. Reasons for inability to perform the essential functions of the position, with or without
  - e. accommodation.
  - f. Absence of current illegal drug use.
  - g. History of loss of license, medical malpractice issues, or felony convictions.
  - h. History of loss or limitation of privileges or disciplinary actions.
- 2) All practitioners must possess a current, unrestricted, and valid license to practice and/or provide covered services in California. License must have been obtained from the State of California from the appropriate licensing board.
- 3) If applicable, must have current medical staff appointment at one or more of the Plan's participating hospitals or clinics, with clinical privileges commensurate with the services to be performed as a participating practitioner.
  - a. Practitioners who demonstrate arrangements for admission through other participating physicians are also acceptable.
- 4) Must be in good standing to provide services under the California State Medi-Cal and Federal Medicare programs
- 5) Physicians: Must maintain American Board Medical Specialties (ABMS) certification or for initial credentialing, have completed a residency program in his/her specialty, be approved by the American College of Medical Examiners (ACME); American Osteopathic Association (AOA); or, other accrediting body acceptable to the Plan/Group.



## COM 7100\_VHP/ SCVMC (GROUP) CREDENTIALING AND RE-CREDENTIALING

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For physicians that are initially credentialed and not board certified (NBC), at physician's next credentialing cycle he/she must be Board certified or provide a written explanation to CC why boards have not been taken.

- a. Board certified physicians will be distinguished from physicians who do not have board certification in the Plan Provider Directories.
  - b. A Primary Care Physician who was initially credentialed before 2007 who has not completed a Residency in a primary care area will be designated as a General Practitioner in Plan Provider directories, and will not be obligated to have completed a residency or maintain ABMS certification for recredentialing.
- 6) Those practitioners required to have DEA's to perform their contractual functions should possess verified current Federal Drug Enforcement Agency Certificate (DEA number).
- 7) All practitioners must have current sanction-free status, no previous criminal felony or specified misdemeanor convictions and must never have had revocation without staying or suspension of License or clinical privileges. Providers with any current or past limitations imposed upon his/her exercise of clinical privileges, or any change in appointment of clinical privileges during the course of his or her participation with the Plan/Group, must supply information to the Plan/Group regarding such limitations. Exceptions are considered based on the following criteria, which requires a special review by the Credentialing Committee:
- a. At any time before the five-year period preceding the date of practitioner's application has ever had his/her medical professional or business licenses revoked or suspended by a state licensing board.
  - b. Within the past five-years from the date of practitioner's application have been convicted of a criminal felony or of any criminal misdemeanor relating to the practice of his/her profession, other health care related matters, third-party reimbursement, controlled substances violations, child/adult abuse charges, or any other matter that, in the opinion of the Plan/Group, would adversely affect the ability of the practitioner to participate with the Plan/Group.
  - c. Ever within the five-year period preceding the date of practitioner's application have been excluded or precluded from participation in the Medicare or Medicaid programs and never have been convicted of Medicare, Medicaid, or other governmental or private third party payer fraud or program abuse, or have been required to pay civil penalties for the same.
  - d. Ever within the five-year period preceding the date of practitioner's application have had his/her medical staff appointment or clinical privileges denied, revoked, or terminated by any health care facility.

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- e. All practitioners must furnish evidence of professional liability insurance coverage in the minimum amounts required by the Plan
  - f. Malpractice Liability Coverage in amounts equal to a minimum of \$1 million per occurrence/\$3 million aggregate.
8. All practitioners must possess malpractice liability history acceptable to the Credentialing Committee.
  - a. Malpractice liability history includes all legal actions involving claims of medical malpractice which have ever been commenced against the practitioner. Any practitioner with a malpractice history shall be subject to review and approval by the VHP Credentialing Committee. Acceptance of malpractice history is based on the following guidelines:
9. During the five-year period preceding the date of the practitioner's 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 physician specialties of obstetrics, neurosurgery, orthopedic, thoracic (cardiovascular and cardiac), and plastic surgery.
  - b. \$100,000 or less for other specialty physicians and primary care physicians will be subject to review and approval by the CC.
10. All practitioners must demonstrate to the satisfaction of the Plan/Group that he/she is capable of providing health care services to Members that meet the standards established by the Plan/Group.
11. All practitioners must be responsible for organizing a pattern of supportive medical resources so that Members may be appropriately served by medical advice and supervision seven days a week and 24 hours a day.

In addition to meeting the above listed minimum requirements, all participating practitioners shall:

- a. Agree to actively participate in and comply with utilization review and quality improvement activities of the Plan/Group and permit Plan/Group representatives to have access to his/her private office for the purpose of conducting on-site audits.
- b. Agree to comply with Plan/Group standards, protocol, policies and provisions specified in the relevant Provider Agreement.

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- c. Supply, upon request, such information regarding the aspects of his/her private practice related to Plan participation.

### ***C) FOR SPECIALIZED PARTICIPATION AS A PCP OR HIV SPECIALIST:***

To qualify to participate as a Plan/Group Primary Care Physician (PCP), a practitioner must meet the following additional qualifications:

1. Have an active practice of medicine in Family Practice, General Practice, Internal Medicine, Obstetrics and Gynecology, or Pediatrics.
2. Be willing and able to supervise, coordinate, and provide initial and basic care to members; initiate their referral for specialist care; and, maintain continuity of patient care in accordance with applicable Plan/Group policies and the Provider Agreement.
3. Be willing and able to accept members and serve as a PCP.

To qualify to participate as an HIV/AIDS Specialist, a practitioner must meet the following additional qualifications:

1. Practitioner must complete and sign form AB2168 (Attachment B).
2. Practitioner must have a designated number of CME's dedicated to HIV Medicine.
3. Practitioner must have a designated number of HIV patients within a given time-period.
4. On an annual basis the Credentialing Coordinator reconfirms the qualifications of the practitioner.

### ***D) VERIFICATION PROCESS***

Primary source verification of applicant qualifications and information is performed by the Provider Relations Specialist, or a contracted Credentials Verification Organization. The following information will adhere to the current National Committee for Quality Assurance (NCQA) standards. Plan/Group acknowledges that the NCQA standards for credentialing are dynamic and shall implement new standards during annual review of the credentialing and Peer Review policy. (Attachment C) delineates the primary source that may be used and the timeframe for completing each element.

### ***E) PROTECTION OF PRACTITIONERS RIGHTS***

Applicants have the following rights:

Review information submitted to support their credentialing application. Request to review

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must be made in advance to the Provider Relations Department. Records will be made available for review at a health plan determined location.

### Correct erroneous information

After completion of verification of the required elements as listed, VHP Credentialing staff will notify the applicant in writing within 10 days of finding any discrepancy between the submitted material and information obtained through the verification process. The applicant has 15 days to reply to VHP regarding discrepancies. Applicants may submit corrections to the Credentialing Specialist through certified mail. A letter of acknowledgement is sent to applicants within three business days upon receipt of corrections. Once the corrected discrepancy document is received by a Credentialing Specialist, the document is date stamped and the staff will re-run the primary source verifications where discrepancy was noted.

### Receive the status of their credentialing or re-credentialing application, upon request.

Applicants may call Provider Relations at (408) 885-2221 to receive information on the status of their application. Applicants are informed of their rights on the applicant checklist sent with the credentialing application, and they are listed on the Plan website.

Applicants are informed of their rights on the applicant checklist sent with the credentialing application, and they are listed on the Plan website. (Attachment A)

### ***F) NOTIFICATION OF CREDENTIALING DECISION TO PROVIDERS:***

All applicants who have submitted a completed application to Plan/Group for participation (initial or re-credentialing) and have been presented to the Credentialing Committee and/or the Medical Director and/or his/her designee are notified of the credentialing decision within 30 days of the Credentialing Committee meeting. All notifications are performed in writing for all Plan/Group practitioners. (Attachment D) The process timeliness of notification is ensured by a sample audit of 15 files per month by the Provider Relations Manager and/or the Quality Management Manager.

1. If practitioner is approved to participate in the Plan an acceptance letter (Attachment D) is mailed, access is given to the online Provider Manual, and Plan Directories are updated accordingly.
2. If practitioner is denied participation to participate in the Plan, a denial letter is sent to the practitioner via certified mail that includes a reason for denial of participation as well as the practitioner's right to appeal Plan's decision.

### ***G) MEDICAL RECORD CONFIDENTIALITY AND FACILITY AND/OR SITE REVIEW***

Medical records of all Plan/Group members, including all other lines of business, are kept confidential and only disclosed to and by other persons within the practitioner's organization only as necessary to provide medical care and quality, peer review, or complaint and appeal review of

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medical care under the terms of the applicable program contract and as required in accordance with applicable laws and regulations. Information contained in the medical record may be used by the Plan/Group or its providers only for a purpose directly connected with the performance of the Plan/Groups' obligations, including enforcement of the member's rights, or as otherwise required by applicable laws and regulations.

### ***H) OFFICE SITE VISIT PROCESS***

Member complaints are reviewed upon receipt regarding practitioner office site concerns (i.e, accessibility, appearance, waiting room, exam room, and equipment) by the Provider Relations Specialist. Site visits will be performed within 60 calendar days of complaint threshold being reported. Practitioner groups that have an MSO function are instructed by the health plan upon delegation and during credentialing oversight visits that all member complaints should be forwarded to VHP's Member Services Department for logging and resolution.

Non-clinical member complaints (Facility Site Review performed by PR) upon re-credentialing as defined in QM COM 6001 "Identifying, Defining, Processing, and Resolution of Potential Quality Issue (PQI) Determination" will be assigned a severity level as specified below:

Severity Level 0: 5 or more Complaints for same provider and/or facility site

Severity Level 1: 4 Complaints for same provider and/or facility site

Severity Level 2: 2 to 3 Complaints for same provider and/or facility site

Severity Level 3: 1 Complaint for same provider and/or facility site

The Medical Record and facility site review, as documented in the Site Audit Tool (Attachment E), includes but is not limited to the following:

1. chart organization
2. preventive health
3. coordination/continuity of care
4. facility standards review which includes physical accessibility and appearance such as handicapped accessible, well-lit waiting room, adequate seating, posted office
5. hours, adequacy of waiting/examining room space and equipment, maintenance of confidentiality and availability of appointments, medical record keeping practices, including compliance with Health Insurance Portability and Accountability Act (HIPAA) for confidentiality of records, security of Protected Health Information (PHI), presence of provision of privacy notice, security of patients files both paper and electronic, storage, and access to records.
6. Access to medical records is permitted only to those individuals who are part of the team-providing healthcare to the individual. The Site Audit Tool denotes the standards and provides a scoring methodology that provides the Provider Relations staff thresholds for scoring in which to score the facility/practitioner.

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An evaluated practitioner and/or facility site must achieve an audit score at or above 90 percent using the criteria for both the facility site review established by the health plan. Practitioners and/or facilities that score below a 90 percent rating must submit a corrective action plan (CAP). The CAP is reviewed by the Credentialing Committee for follow-up and the site is re-audited within six months to confirm compliance. Results below 90 percent on two consecutive audits require a minimum waiting period of 12 months before the applicant is reconsidered for Plan/Group participation.

### ***I) RE-CREDENTIALING***

Re-credentialing is completed for determination of continued participation with the plan no longer than every three years (36 months) after the previous credentialing determination.

Practitioners going through the re-credentialing process are required to complete and submit a signed, current attestation questionnaire and release of information page. Please note- Practitioners who terminate the Plan/Group and do not return until 30 days after the termination date, are required to repeat the initial credentialing process.

VHP Provider Relations staff complete the steps outlined in the credentialing process, including verification of all necessary information from primary sources. Except for verification of residency training, education, and work history, the following information is attested to in the application:

1. Reasons for inability to perform the essential functions of the position, with or without accommodation.
2. Absence of illegal drug use.
3. History of loss of license or felony convictions.
4. History of loss or limitation of privileges or disciplinary actions.

In addition to the qualification verification, the CC is presented with a report detailing practitioner performance in the following quality improvement target areas to assist in evaluation of the practitioner's compliance with the Provider Agreement provisions and Quality Improvement Program standards:

1. Member complaint history including a summary of quantity, category, and outcome of complaints related to practitioner.
2. Results of quality review studies, if any, related to the practitioner.
3. Member satisfaction survey results specific to practitioner including a Plan assessment of accessibility, appointment availability, and wait times.

### ***J) ONGOING MONITORING***

VHP conducts on-going monitoring of practitioners through review of appropriate licensing boards and California monthly reports and/or "hot sheets" and every 30 days but not less than

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monthly review of excluded practitioner reports for sanctions. In addition, every 30 days, but not less than monthly, Medicare Opt-Out (Northern and Southern California) Report is printed and reviewed to ensure practitioner has not opted out of Medicare. Ongoing monitoring of license sanctions or limitations and Medicare/Medicaid may be conducted through participation in the NPDB-HIDB continuous query process. Applicants are enrolled at the time of credentialing with enrollment maintained on an annual basis. If during Ongoing Monitoring it is found that a practitioner has been convicted of a criminal felony or of any criminal misdemeanor relating to the practice of a medical profession, other health care related matters, third-party reimbursement, controlled substances violations, child/adult abuse charges, or any other matter that, in the opinion of the Plan/Group, would adversely affect the ability of the practitioner to participate in the Plan/Group, the findings will be presented to the CC for termination. Practitioners who the Medical Board of CA notifies VHP that the license has been suspended or restricted will be sent to the CC for termination as the practitioner is no longer meeting the contractual requirement for having an unrestricted license in order to participate in the network.

### ***K) COMPLAINTS AND ADVERSE EVENTS***

VHP investigates practitioner-specific complaints from members upon receipt. The evaluation includes the specific complaint and the practitioner's history of issues, as appropriate. Based on the severity and the number of complaints, the practitioner is reviewed by the CC for appropriate action. Adverse actions (an injury that occurs while a member is receiving health care services from a practitioner) are reviewed upon receipt by the Medical Director and may be brought to the CC if it is a validated quality concern. For range of actions refer to QM COM 6001 - IDENTIFYING, DEFINING, PROCESSING, AND RESOLUTION OF POTENTIAL QUALITY ISSUES (PQIS) AND QUALITY ISSUE DETERMINATION

#### Adverse Clinical and Practice Complaints (investigation and/or facility site review performed by QM)

Severity Level 0: 5 or more Complaints for same provider  
Severity Level 1: 4 Complaints for same provider  
Severity Level 2: 3 Complaints for same provider  
Severity Level 3: 2 Complaints for same provider

### ***L) PRACTITIONER CREDENTIALING /RE-CREDENTIALING RECOMMENDATIONS AND ACTIONS***

Following completion of the review, evaluation, and verification of applicant qualifications, the Credentialing Specialist documents the outcome of the process for each applicant. The Medical Director and/or his/her designee have the authority to approve a "clean file" outside of the Credentialing Committee as needed. For a file not designated as a "clean file", a report of evaluation outcomes and participation recommendations are reviewed with the Medical Director and/or his/her designee and presented to the Credentialing Committee for a formal decision. The CC may approve, delay, or deny an applicant upon review of the documentation presented.

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1. For initial credentialing, a “clean file” is considered to be an initial practitioner file that meets all the criteria set forth in this policy as well as absence of pending and/or completed judgments/settlements that have not been reviewed by the Credentialing Committee.
2. For re-credentialing, a “clean file” is considered to be a practitioner file that meets all the criteria set forth in this policy as well as absence of new pending and/or completed judgments/settlements that have not been reviewed by the Credentialing Committee since the initial credentialing approval date.
3. A credentialing/re-credentialing application and/or notification from the Medical Board of California is forwarded to the CC for a recommendation of limitation and/or denial of participation in the Plan for the following circumstances: Practitioners who do not return their recredentialing application within the required timeframe to recredential them within 36 months will be sent to the CC for termination from the plan.
  - a. Inability to score the required 90% or greater, on an office site visit as a result of a complaint.
  - b. Failure to meet or maintain minimum qualifications criteria or additional criteria established by the Plan/Group.
  - c. Responses to verification of education, license, sanctions, malpractice coverage, or other qualifications that do not meet minimum standards. Should the practitioner be a PCP, the PCP’s member assignment panel will be closed to new membership until CC has an opportunity to review file.
  - d. If a practitioner does not maintain a valid, current, unrestricted license, he/she does not meet criteria, so it does not go to committee.
  - e. Practitioners who have been convicted of a criminal felony or of any criminal misdemeanor relating to the practice of a medical profession, other health care related matters, third-party reimbursement, controlled substances violations, child/adult abuse charges, or any other matter that, in the opinion of the Plan/Group, would adversely affect the ability of the practitioner to participate in the Plan/Group.
  - f. Practitioners who have had medical staff appointment or clinical privileges denied, revoked or terminated by any health care facility.
  - g. At any time during the five-year period preceding the date of the practitioner’s initial application, more than two legal actions have been commenced and the aggregate amount of the resulting judgments and/or settlement was:



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- i. More than \$250,000 for the surgical physician specialties of obstetrics, neurosurgery, orthopedic, thoracic (cardiovascular and cardiac), and plastic surgery.
- ii. More than \$100,000 for other specialty physicians and primary care physicians.
- h. At any time during the three-year period preceding the date of the practitioner's application for re-credentialing, three or more legal actions resulted in judgments and/or settlements above the limits as stated above.
- i. Failure to provide professional services of acceptable quality as determined by the Plan to meet criteria as specified in policy.
- j. Repeated failure to follow Plan utilization review policies.
- k. Repeated failure to follow or comply with Plan quality of care standards.
- l. Failure to meet the standards and provisions of the relevant Provider Agreement.

### ***M) PRACTITIONER SUSPENSION/TERMINATION PROCEDURE***

1. Notification is promptly made to the practitioner by the Medical Director, and/or his/her designee, via certified mail, regarding all actions made by the Plan/Group that constitute grounds for a hearing as listed herein (Attachment F).
2. The notice of action includes the action being proposed, the effective date of the action, a statement of reasons for the proposed action, notice that the provider has a right to request a hearing with the CC within 30 days, and a summary of the practitioner's rights in the hearing.
3. The Medical Director will report notification of action to the appropriate Board of California, National Practitioner Data Bank, and contracted health plans, pursuant to Business and Professions Code Section 805; as well as filing an 805.01 form to the Medical Board of California within 15 business days.
4. Practitioners may file an appeal for a hearing regarding Plan actions of denial, termination, sanction, or reduction of participation when the cause of the action is related to clinical competency or professional conduct. Practitioners appealing a decision by the Credentialing Committee must submit documentation in regards to the appeal.

### ***N) GROUNDS FOR HEARING***

1. Except as otherwise specified in this Credentialing Policy, any one or more of the following actions or recommended actions shall constitute grounds for a hearing:

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2. Involuntary termination of the practitioner's ability to treat Plan Members as a Participating Provider when the reason is due to a medical disciplinary action or due to reasons of clinical competency or professional conduct.
3. Involuntary termination of the provider's Services Agreement with the Plan when the reason is due to a medical disciplinary action or due to reasons of clinical competency or professional conduct.
4. Denial of a practitioner's application to become a participating provider with the Plan when the denial is based upon medical disciplinary reasons or based on reasons of clinical competency or professional conduct.

The practitioner must exhaust the remedies afforded by the Plan Credentialing Policy and CC Hearing Policy before resorting to arbitration action. Otherwise, the practitioner shall have waived the hearing and appeal rights of the Plan and shall have to accept the recommendation or action involved.

### ***O) REQUEST FOR HEARING***

The practitioner has 30 days from the date of receipt of notification of action in which to request a hearing by the CC. The request must be received in writing, addressed to the Plan Medical Director and/or his/her designee, and include the rationale and supporting documentation for the hearing. The Medical Director and/or his/her designee will coordinate all notifications, arrangements, and requests related to the hearing process. The date of the hearing will not be less than 30 days and not more than 60 days from the date of original notification of action to the practitioner.

The practitioner will be notified by mail of the date and time of the hearing. The hearing notification will include the following: a list of any witnesses expected to testify on behalf of the Plan at the hearing and a statement of the practitioner's rights in the hearing process.

The practitioner's rights in the hearing process are:

1. A licentiate shall have the option of being represented by an attorney at the licentiate's expense. No peer review body shall be represented by an attorney if the licentiate is not so represented.
2. Generation of a record of the proceeding, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with their preparation.
3. Submission of a written statement at the close of the hearing.

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The practitioner will be notified that failure of the practitioner to appear at the hearing, without good cause, forfeits his/her rights to the hearing and the action shall become effective immediately. In the event the practitioner does not request a hearing as required within the 30-day time-period, he/she will be deemed to have accepted the action involved and it will become effective immediately.

### ***P) CREDENTIALING COMMITTEE HEARING POLICY***

Processes, procedures, and policy for a CC hearing regarding Plan credentialing actions when the actions are due to reasons of clinical competency or professional conduct are stipulated in the Group's by-laws on Fair Hearing.

### ***Q) REPORTING AND FAIR PROCEDURE RIGHTS***

If, as a result of the approval or re-approval action taken pursuant to this policy and procedure, a practitioner's status as a participating practitioner is denied, suspended, restricted, or terminated for a medical practice disciplinary cause or reason, a report will be filed within 15 days, and/or as required by applicable law, including California Business and Professional code 805 and 805.01 and Health Care Quality Improvement Act. Furthermore, all Contracted Health Plan's will be notified via letter of the disciplinary action.

In the event that an approval or re-approval action pursuant to this policy and procedure results in a report to the relevant licensing agency pursuant to California Business and Professional Code Section 805 and 805.01, the practitioner shall be offered a notice of hearing rights in compliance with California Business and Professional Code Section 809 et.seq.

## **V. MAINTENANCE OF FILES AND PLAN DIRECTORIES**

A paper file record will be maintained for each practitioner including the application and any additional paper documentation related to the practitioner's participation. Information concerning Quality Improvement, Peer Review, Sanctioning and Site Surveys, will be filed in separate subsections within the physician file to allow for compliance with confidentiality and discovery criteria. The data maintenance records will include the identity of the individual verifying all credentialing information and the date of the verification.

A credentialing and practitioner participation status database system will be maintained and used to store the specific practitioner demographic information utilized by the Plan to prepare directories and to perform administrative functions such as PCP assignment, member services, utilization management and quality improvement. The Provider Relations Specialist/Credentialing Specialist will maintain paper and computer database records and update them regularly to reflect any changes, activity, and actions related to a specific practitioner as they occur. As the acting Medical Services Organization, VHP is responsible in distributing this data to all SCVMC contracted and/or delegated health plans.

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The Provider Relations Specialist notifies Marketing and Communications of changes to the network. The Provider Directory is updated with the changes on a quarterly basis. Provider Relations updates the database of changes to the network and notifies Member Services immediately by way of email. The practitioner information is updated from the Access database in the Provider Directory. The database is updated upon the CC approval and a profile sheet is created and sent back to Credentialing Specialist to assure accuracy. The System used by VHP is updated at the same time so Member Services has immediate access to practitioner inclusion and information specific to the provider. Member Services receives information on education and training directly from the PR Department and from the website.

### ***A) ACCESS TO CREDENTIALS FILES***

Credentials files and quality files are maintained and protected under state law protecting such records from discovery.

Persons within the organization, including specified officers, employees, and agents, may access credential and quality files in the course and scope of their duties for or on behalf of the organization to the extent necessary to perform those duties. Such persons include the VHP Medical Director, and/or his/her designee, CC, VHP Provider Relations Credentialing Staff. A practitioner or their authorized representative may review his or her own credentials or quality file subject to applicable law and policies and procedures governing access to confidential and privileged information.

Persons outside the organization, including accreditation bodies and authorized representatives of State and Federal agencies, may access credentials and quality files to the extent and in the manner expressly authorized by applicable law and/or contract. The VHP Provider Relations Manager shall determine, in consultation with legal counsel, whether law and/or contract authorizes the access requested.

### ***B) CONFIDENTIALITY***

Credentialing files and quality files are maintained as protected under state law protecting such records from discovery. Plan will maintain all practitioner files within a locked secure environment. All practitioner files, including the computer database in Access, shall be considered confidential. Only authorized persons within the organization may access credentialing files and/or the credentialing database in Access, in the course and scope of their duties for or on behalf of the organization to the extent necessary to perform those duties. When not in use, the computer is locked so confidential information is not available except to the Provider Relations Staff. Staff receives training annually on maintaining confidentiality.

All discussions and decisions made by Plan/Group's Credentialing Committee will be kept confidential. Credentialing information is not sent electronically and papers are collected and shredded at the end of the CC meeting. To ensure this, the sign-in-sheet has a statement which

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includes all materials and discussions from the meeting are to be treated as confidential and peer review.

## **VI. DELEGATED CREDENTIALING**

The Plan may delegate application collection and credential review, evaluation, and verification to authorized practitioner entities who can demonstrate compliance with this policy through a pre-delegation review performed by the Provider Relations Specialist or Provider Relations Manager. The results are presented to the CC. The pre-delegation review of the provider entities' credentialing policies and procedures, as well as an audit of delegate's credentialing files, using any of the following methodologies as deemed appropriate in which the PR Specialist or PR Manager selects a random sample of credentialing or re-credentialing files from the delegate's files from the previous 12 months:

1. 8/30 file review process
2. Reviewing five percent of the files or 50 files, whichever is less or
3. At a minimum, 10 credentialing files and 10 re-credentialing files (if the delegate has less than 10 practitioners credentialed or re-credentialed within the previous year, the
4. audit may include all practitioners processed that year).

For every year after the initial audit the Plan may choose to perform a desk top delegated credentialing audit, provided that the IPA/Group can meet one of the following criteria:

1. Has provided quarterly ICE reports to the Plan (Attachment G)
2. Provides NCQA accreditation certificate that is valid for no less two years that demonstrates that credentialing was part of the review.
3. The Plan retains the right to conduct an annual evaluation of the delegate in the same manner as conducted during the pre-delegate review.

The final determination of the qualifications of individual practitioners to participate in the Plan will remain the authority of the Plan as outlined in this policy. Delegated Credentialing Entity shall comply with the credentialing policies and procedures specified in this policy.

An alternate application, which collects the same information as the Plan application, may be utilized with prior Plan approval. Delegated Credentialing Entity will maintain the original practitioner application at their physical location. Delegated Credentialing Entity shall also provide Plan, either electronically or in hard copy, with a report detailing certain data elements for each practitioner. The format of this report shall be specified by Plan.

The delegated credentialing entity provides the Plan with an individualized report detailing the qualification findings for each practitioner seeking participation, along with the primary source verification dates so that the Plan can affirm that the dates of PSV fall within the required timeframes when the Plan makes the final decision. The qualifications findings report will

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specify any qualification, which the practitioner does not satisfy and give detailed explanation of the nature and/or cause of failure to meet the qualification. Delegate will also be required to provide the Plan, on an at least semi-annual basis, reports that may include, at a minimum, additions and deletions to the delegate's practitioner network, turn-around time for process and notifications, and other information as may be agreed upon in a Delegate Agreement.

The Delegated Credentialing Entity shall provide the Plan with immediate notification of any disciplinary action taken against a participating practitioner and/or any change in the practitioner's appointment status or restriction of license and/or limitation on the practitioner's clinical privileges.

The Plan reserves the right to request the credentialing minutes from the Delegated Entity's Credentialing Committee's determination.

Recommendation for initial and continued participation of practitioners for whom the credentialing process has been completed by a Delegated Credentialing Entity will be made to the Credentialing Committee in accordance with the criteria specified in this policy. The Plan retains final decision on inclusion of individual provider's participation in the Plan.

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## PREVIOUS REVISION DATES

Last Revision: May 19, 1997	Last Revision: August 23, 2000
Reviewed by: Medical Director	Last Revision: October 18, 2001
Approved by: Credentialing Committee	Last Revision: September 5, 2002
	Last Revision: April 21, 2003
	Last Revision: October 19, 2005
	Last Revision: December 20, 2006
	Last Revision: August 15, 2007
	Last Revision: December 17, 2008
	Last Revision: December 17, 2009
	Last Revision: December 22, 2010
	Last Revision: December 21, 2011

*Attachments are hyperlinked*

[Attachment A](#) – Participating Physician Application Packet Cover Sheet

Attachment B – AIDS / HIV Attestation Questions

Attachment C – Verification Process Attachment D – Credentialing Approval Letter

[Attachment E](#) – Audit tool

Attachment F – Termination from Plan

Attachment G – ICE Quarterly Submission Form



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