Ventura County Health Care Plan

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County of Ventura

Physician Operations Manual

Revision History: Aug. 12, 2009 (LCK); April 2011 (LCK); February, 2013, C. Glueckert, M. Craig and M. Craven

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Section 1 - Introduction

About the *Ventura County Health Care Plan (VCHCP)*

The Ventura County Health Care Plan (VCHCP) was formed in November 1993 under a California state law which then allowed a public entity to operate a health care plan without being licensed by the State if the plan provided healthcare services only to its employees, retirees, and their dependents. In 1994, VCHCP's first full year of operation, total enrollment in the plan grew to just under 2,000 members.

On June 7, 1996 the Department of Corporations (now known as the "Department of Managed Health Care") issued a "full service" Knox-Keene health plan license to VCHCP. The license permitted the Plan to enroll members within the geographic boundaries of the County of Ventura, an area of 1,873 square miles, including 43 miles of coastline.

On June 1, 1998 the Plan received approval to participate in the State-sponsored Healthy Families Program administered by the Managed Risk Medical Insurance Board (MRMIB). Since that time enrollment in this program has grown to over 10,000 children.

At present, VCHCP has two lines of business, commercial and State-sponsored. Commercial products include large group, small group and individual benefit plans. State-sponsored programs include Healthy Families, and the Access to Infants and Mothers (AIM) program. In addition, the Plan began to offer a Medicare Coordination of Benefits (COB) plan to Medicare-eligible County retirees.

Services are provided to members by a combined network of providers consisting of the Ventura County hospital and ambulatory care system, and contracted community hospital and physician providers. The Plan prefers that, to whatever extent possible, its members receive their services from the Ventura County healthcare system. Tertiary care services, including transplant services, are made available by the plan through several southern California healthcare institutions.

Please refer to Appendix E for the names and locations of the Ventura County Healthcare System inpatient and ambulatory care facilities.

Section 1 - Introduction

Purpose of the Operations Manual

We developed these guidelines to help explain our plan policies and billing procedures and to help *Ventura County Health Care Plan* (VCHCP) network providers understand their responsibilities. This update replaces in its entirety any previous version of the *Ventura County Health Care Plan Physician Operations Manual*.

This Operations Manual is also used to ensure that VCHCP providers have access to needed information to ensure members enrolled in our benefit plans receive appropriate covered services when needed. VCHCP benefit plans are underwritten by the County of Ventura and are regulated by the California Department of Managed Health Care (DMHC) and the Managed Risk Medical Insurance Board (MRMIB).

The information in these guidelines applies to providers who have signed an agreement with VCHCP to participate as a network facility. The term "provider manual" in the agreement refers specifically to this *Operations* manual.

These guidelines describe general policies and procedures. Please refer to your agreement for specific terms and conditions.

Section 1 - Introduction

Operations Manual Orders and Updates

The Ventura County Health Care Plan will periodically update this manual, and we will notify you when material content changes occur.

View this manual online. For your convenience, we have made this manual available to you online at Provider Connection, VCHCP's provider Web site. To access Provider Connection, go to www.vchealthcareplan.org.

To learn more about our Provider Connection, see the following pages in this section.

If you wish to order additional printed copies of this manual, please contact Member/Provider Services:

Member/Provider Services
Ventura County Health Care Plan
2220 E. Gonzales Road Suite 210-B
Oxnard, CA 93036

(805) 981-5050 or (800) 600-8247

Section 1 - Introduction

Provider Connection

Provider Connection is your online resource for quick and convenient information on our medical policies and procedures, member benefits and eligibility, preferred drug list (formerly known as the “drug formulary”) and more. It gives you access at any time to:

- Refer to our provider manuals for guidelines on administrative policies and procedures, including medical management, billing procedures, claims processing and more (located in the Guidelines and Resources)
- Review claims payment status (updated nightly)
- Review our Benefit Guidelines for current coverage information
- Access disclosure information mandated by the AB1455 Regulations
- Review Preventive Health Guidelines based upon the recommendations of the U.S. Preventive Services Task Force Guide to Clinical Preventive Services

Future updates to our Web site will enable our providers to:

- Obtain member eligibility (including history) and detailed benefits information (updated nightly)
- Review a summary of member benefits
- Download detailed member benefits
- Search the VCHCP preferred drug list by drug name, brand name and therapeutic category.
- Obtain authorization contact information and download authorization forms
- View provider network updates
- Obtain names and telephone numbers for VCHCP departments such as Provider Relations, Member Services, and Medical Management
- Review our Clinical Practice Guidelines (a summary of evidenced based recommendations) and get the most current information on new technology and procedures approved for coverage.

How to Access Provider Connection

To access Provider Connection, go to **www.vchealthcareplan.org** and click on "Provider Connection" in the section "Information for Providers”.

Section 1 - Introduction

Key Health Plan Contacts

General Plan Address:

Ventura County Health Care Plan
2220 Gonzales Road, Suite 210-B
Oxnard, CA 93036

Plan Administration:

Dee Pupa (Interim) (805) 981-5006

Medical Director:

C. Albert Reeves, M.D.
(805) 981-5024

Dir. Health Services:

Faustine Dela Cruz
(805) 981-5058

Utilization Management:

Position Currently Vacant

Services Administrator:

Cathy Glueckert
(805) 981-5039

Member Services:

Maria Garcia, Lead
(805) 981-5091

Claims Processing:

Michelle Craig, Supervisor
(805) 981-5037

'After-Hours' Contact Information:

A Medical Director or a Plan Administrator are always on-call after normal business hours, and can be reached by calling the Plan's main telephone number, (805) 981-5050, or (800) 600-8247 and selecting the appropriate number for on-call assistance.

Section 1 - Introduction

VCHCP Member Services Center

Member Services Representatives are available Monday through Friday to answer questions concerning:

- Member eligibility
- Covered services/benefits
- Deductibles and copayments
- Claims status

Member Services representatives can be reached during the hours of 8:30 a.m. to 4:30 p.m. by calling (805) 981-5050 or (800) 600-8247.

TDD to Voice (800) 735-2929; Voice to TDD (800) 735-2922

www.vchealthcareplan.org

Providers or members wishing to find out more about behavioral health services can call the plan's behavioral health program administrator, Optum Health Behavioral Solutions, at (800) 851-7407.

Section 1 - Introduction

California "Department of Managed Health Care" (DMHC) Access Numbers and Web Site

The California Department of Managed Health Care (DMHC) is responsible for the regulation of Knox-Keene licensed health care service plans. If the member has a grievance against the VCHCP, they should first telephone the VCHCP at the number provided in their Evidence of Coverage booklet and use our grievance process before contacting the DMHC.

Utilizing the VCHCP's grievance process does not prohibit any potential legal rights or remedies that may be available to the member. If the member needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the VCHCP, or a grievance that has remained unresolved for more than 30 days, the member may call the DMHC for assistance.

The member may also be eligible for an **Independent Medical Review** (IMR). If they are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by VCHCP 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.

DMHC has a toll-free telephone number **(888) HMO-2219** and a TDD line **(877) 688-9891** for the hearing and speech impaired. DMHC's Internet Web site, **www.hmohelp.ca.gov**, has complaint forms, IMR application forms and instructions online to assist plan members.

Section 1 – Introduction

Fraud Prevention

Each year, healthcare fraud costs consumers hundreds of millions of dollars. Health care fraud wastes precious funds, threatens the healthcare system, and victimizes consumers. The VCHCP has a team of professionals working to combat this problem. You can help us to stop this serious problem by learning more about it and reporting suspicious incidences.

Health care fraud is defined as making, using or causing to be made or used any false record, statement, or representation of a material fact for use in determining rights to any benefit or payment under any health care program. Health care fraud can be committed by a provider, member, employer group, or by the Ventura County Health Care Plan (VCHCP) personnel. Any one indicator or combination of indicators does not in itself signify fraud. Rather, it only calls attention to circumstances that are sufficiently out of the ordinary that they might represent fraudulent activity and should be investigated further.

Health care fraud can be any scheme used by any provider of services for the purpose of personal or financial gain by means of false or fraudulent pretenses, representation, or promises. Health Care Fraud can also be the commission of acts of deception, misrepresentation, or concealment by any member or Subscriber group in order to obtain something of value to which they would not otherwise be entitled.

Our Special Investigations unit also investigates suspect billing practices. You can access the VCHCP Fraud Prevention link on our Web site for guidance on billing procedures and prevention of inappropriate practices.

Section 1 - Introduction

Code of Business Conduct and Compliance Program

The VCHCP sends newly contracted providers a letter with a welcome package that describes the VCHCP Standards. However, at all times providers are requested to help VCHCP uphold these standards by contacting the VCHCP if they are concerned that a VCHCP employee is not acting in compliance with our Code of Business Conduct, or if they have questions about VCHCP's standards of business conduct. Those standards are as follows:

The *Ventura County Health Care Plan,* owned and operated by the County of Ventura, is committed to the values of honesty and integrity in all of our business dealings, values for which we have been known since our formation in 1993. To emphasize the importance of our high standards, we have adopted a Code of Business Conduct and Compliance Program. The Code of Business Conduct requires that all of our employees:

- Conduct activities in accordance with all applicable laws and regulations,
- Avoid allowing any outside financial interests to influence decisions or actions taken on behalf of VCHCP,
- Protect confidential and proprietary information,
- Avoid purchasing goods or services without VCHCP approval from any business in which a team member or close relative has a substantial interest,
- Record and report all business information fully, accurately and honestly,
- Avoid offering or accepting entertainment which is primarily intended to gain favor or influence,
- Avoid compensation, gifts, recompense or incentives or any other form of personal gain due to the purchase of goods or services from a supplier or customer,
- Prevent unauthorized use of VCHCP or VCMC Information systems, and
- Avoid using VCHCP funds or assets for any unlawful or unethical purpose.

To help us uphold our code of Business Conduct and Compliance Program's standards we request your support and cooperation with our efforts. All VCHCP team members are expected to comply with the Code of Business Conduct and to report any actual or suspected violations of the Code. If you suspect that any of our team members have violated any of the Code's prohibitions, you may report any incidents directly to the Plan Administrator by calling **(805) 981-5022**.

Section 2 – Member Services

Member Rights & Responsibilities

Members/Enrollees of VCHCP have the right to receive information about, and make recommendations regarding, their rights and responsibilities.

They have the right to:

- Receive information about VCHCP and the covered services under our plan/policy and written in languages that represent the major population groups served by VCHCP.
- Get up-to-date information about the physicians and hospitals who participate in the plan.
- Be told how to submit a complaint or grievance regarding VCHCP or contracting providers, or request appeals for denied services.
- Change from one primary care physician to another available primary care physician who participates in the plan.
- Be told how to get in touch with their primary care physician or a back-up physician 24 hours a day, every day.
- Be treated with dignity and respect and have their right to privacy recognized in accordance with state and federal laws.
- Discuss and actively participate in decision-making with their contracting provider regarding the full range of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.
- Refuse any treatment or leave a medical facility, even against the advice of a contracting provider. Their refusal in no way limits or otherwise precludes them from receiving other medically necessary covered services for which they consent.
- Complete an Advance Directive, living will or other directive and provide it to their contracting provider to include in their medical record. Treatment decisions are not based on whether or not an individual has executed an advance directive.
- Expect that the confidentiality of their personal health information will be maintained in accordance with HIPAA and other legislative regulatory requirements.

- Exercise these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for their health care.

Members Also Have Responsibilities, And They Include the Responsibility to:

- Review information regarding their benefits, covered services, any exclusions, limitations, or copayments, and the rules they need to follow as stated in their Evidence of Coverage.
- Choose a primary care physician from the plan's network and form an on-going patient-physician relationship.
- Tell a treating physician if they do not understand the treatment they are receiving, and ask questions if they do not understand how to care for an illness.
- Provide VCHCP and contracting providers, to the degree possible, the information needed to provide appropriate care to them, including disclosure of all current medications.
- Follow treatment plans and care instructions as agreed upon with their network provider. Actively participate, to the degree possible, in understanding and improving their own medical and behavioral health condition and in developing mutually agreed upon treatment goals.
- Accept their financial responsibility for health plan premiums, any other charges owed, and any copayment or coinsurance associated with services received while under the care of a contracting provider or while a patient in a facility.
- Treat physicians and all providers, their staff, and the staff of the health plan with respect and courtesy.

If they have questions or concerns about their rights, please tell them to contact VCHCP Member Services at the phone number listed on their membership card. If they need help with communication, such as help from a language interpreter, Member Services (805) 981-5050 or (800) 600-8247 representatives can assist them.

Section 2 – Member Services

Member Grievance Process

VCHCP administers the investigation and resolution of member grievances and appeals. This process follows a standard set of policies and procedures. The process also encourages communication and collaboration on grievance issues among various VCHCP departments. VCHCP requests that contracted hospitals and physicians become familiar with the member grievance process (see Appendix A for a description of this process) and suggest members use it rather than other alternatives such as binding arbitration. VCHCP member contracts require binding arbitration to settle member disputes.

Section 3 – Physician Provider

VCHCP Provider Standards

Providers agree to promote the interest of the VCHCP and its members and, through their own conduct, to uphold the good name of the VCHCP.

- Providers deliver to the VCHCP subscribers quality medical services that are cost-effective and meet prevailing community standards. In the delivery of health care services, providers do not discriminate against any person because of race, color, national origin, religion, sex, sexual orientation, disability, or physical or mental handicap. Providers seek to educate and encourage subscribers to follow health practices that improve their lifestyle and well being.
- VCHCP providers agree not to refer members for non-covered services or perform non-covered services unless the member signs an acknowledgement of financial responsibility.
- Providers maintain appropriate licensure for their practice, as well as for any individuals for whom they have direct responsibility, and restrict their practice to the scope of their licensure.
- Physician providers abide by the code of ethics established by the Judicial Council of the American Medical Association and the VCHCP Medical Policy.
- Providers agree to ensure that claims submitted to VCHCP are coded accurately paying particular attention to the CPT and ICD-9 descriptors used as well as accurately reflecting the provider of service.
- Providers who have been disciplined by a professional or governmental body in authority, or who have been placed on review by the VCHCP for an extended period of time for not modifying their practice or billing pattern, understand that they may be expelled from membership. Providers further acknowledge that appropriate discipline may be taken should they be found guilty of fraud, willful misrepresentation, or materially departing from accepted practice standards, including providing medically unnecessary services.
- Providers assure accurate, complete, and timely recording of medical records while observing the requirements for confidentiality.
- Providers cooperate with the VCHCP practices and procedures and honor the terms and conditions of the subscriber's health care service plan. Providers refer subscribers to other VCHCP contracted providers and admit subscribers to the VCHCP preferred hospitals. Physician providers actively support appropriate utilization of hospital

facilities and ancillary medical services, and abide by review procedures and decisions of professional peer review, as well as the VCHCP Medical Policy.

- Providers agree to provide services within a reasonable time period, as defined in the access-to-care guidelines contained in **Appendix A**.

Section 3 – Physician Provider Responsibilities

Patient Advocacy

The patient's physician is responsible for being an advocate on behalf of VCHCP patients. Physicians can do this in a number of ways. For example, you should familiarize yourself with the "Member Rights and Responsibilities" information included in the Member Services section of this manual, and help our members understand that they should take an active role in maintaining their health. In particular, let them know that they should ask you for clarification if they do not understand that they should take an active role in maintaining their health.

Also, please understand that nothing in your participating provider agreement or our policies should be construed to prohibit, limit or restrict you from advocating on behalf of your patients.

Language Assistance

PROVIDER shall comply with VCHCP's Language Assistance Program standards and methods developed pursuant to the Knox-Keene Act and Regulations. PROVIDER shall cooperate with VCHCP and provide it with all information requested to enable VCHCP to assess such compliance by PROVIDER. The Language Assistance Program is provided to Enrollees free of charge. If an Enrollee declines the services of an interpreter, PROVIDER shall document that declination in the Enrollee's medical record or patient file.

Purpose

To establish the overall responsibilities of the Primary Care Physician (PCP), Specialists, and Ancillary Providers in the provision and/or delivery of Language Assistance services to non-English proficient members.

Scope

The Plan communicates language assistance program requirements to the network providers through the Physician Operations Manual (which is posted on the Provider Website), as well as in the provider contract. Contracted providers receive monthly enrollment reports from the Plan which include the members' language preferences.

Providers are expected to make sure that patient needs are met pertaining to language interpretation for non-English proficient patients if the doctor or his/her present staff member are not medically fluent in the patient's preferred language. The physician's office should contact the Plan in advance of such members' appointments to ensure that an interpreter has been arranged for such members. The Plan will then schedule an interpreter for the appointment.

All physicians are advised that the use of family members as interpreters is discouraged, as most people are not medically fluent in language translation. Such issues can create a communication gap which can limit the patient's ability to relay issues correctly, thus adversely affecting medical care. If the physician or a staff member is going to serve as the interpreter, such interpreter must have an attestation form on file with the Plan that such person is medically proficient in language interpretation for such language.

For more information on the subject as well as to stay informed of any Language Assistance Program updates, all providers are strongly encouraged to regularly review the Plan's Language Assistance Program Description.

Section 3 – Physician Provider Responsibilities

Provider Credentialing

The following documents comprise the standards for credentialing and will be current at the time the credentialing decision is made and are maintained in the Credentialing file:

1. Current State Medical License

   All providers must be licensed by the state for the specialty in which they practice. Current State medical licensure must be obtained by direct confirmation from the State Medical Board, either on-line, by mail or by phone. Verification of other licenses held will be done with the appropriate State's Medical Board or Federation of State Medical Boards query.

2. Verification Of Clinical Privileges In Good Standing From The Applicant's Primary Admitting Facility

   All providers must have admitting privileges at a VCHCP contracted hospital, except as noted. Verification of clinical privileges in good standing to perform the functions for which he/she is contracted at the hospital designated by the provider as the primary admitting facility is confirmed in writing or orally and includes the date of appointment, scope of privileges, restrictions, and recommendations.

Note: If the hospital will not confirm "good standing," a letter stating this must be included in the applicant's credentialing documents. If a published hospital list is used, the list must include the necessary information and be accompanied by a dated letter from the hospital attesting that the provider is in good standing. All rosters must be dated and have identifying information from the hospital.

If the provider does not have admitting privileges, a statement confirming coverage for any inpatient work will be included in the file and reasons for the exception documented. Arrangements for the admission and treatment of hospital patients by a VCHCP approved provider must be established in a written agreement with the covering provider. On-call coverage must also be provided by a VCHCP approved provider.

Note: Exceptions to current clinical privileges may be considered on a case by case basis by the Credentialing Committee

3. Valid DEA Or CDS Certification

   All providers, except non-prescribing providers, must have a valid DEA or CDS certificate.

   Note: A photocopy of the current DEA certificate is considered to be sufficient verification, as is visual inspection. The 120 day limit does not apply to verification of DEA certificates. However, the provider's certificate must be effective at the time of the credentialing decision.

4. Verification of Education and Training

   All providers must have completed appropriate education and training for practice in the designated specialty. Only the highest level of credentials must be verified.

5. Verification of Board Certification, Candidacy, as Applicable

   Board Certification is required (effective in 2012) and must be verified.

6. Work History

   At least five years of work history. This may be in the form of a curriculum vita, providing it has adequate information with regard to work history. Any gaps in work history will be investigated.

7. Current, Adequate Malpractice Insurance

   All providers must be appropriately insured according to provider organization's guidelines. Professional Liability Insurance coverage and amounts of coverage must be verified either with the insurance carrier or from the provider. The coverage must be current, and meet VCHCP's standards.

   Note: The generally accepted industry standard is a minimum of $1 million per claim and $3 million annual aggregate. If the policy is a "claims made" policy, tail coverage is required and verified.

8. Professional Liability Claims History

   Professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner

   Verification of claims history must be obtained from the current and/or previous carriers and the public record as necessary. At least five years of claims history must be reviewed.

   Note: The National Practitioner Data Bank may be queried in lieu of verification of history from the carriers.

9. Application For Membership Including A Statement Consistent With Applicable Laws, Signed By The Applicant And Addresses the following:
   a. Physical and mental ability to perform essential functions of the position, with or without accommodation;
   b. Lack of impairment due to chemical dependency/substance abuse;
   c. History of loss of license;
   d. History of felony convictions;
   e. History of loss or limitation of privileges;
   f. History of disciplinary activity;
   g. Malpractice insurance coverage consistent with limits established by VCHCP; and

10. Attestation as to the completeness and accuracy of the application. A prospective practitioner office on-site visit report is required of new PCP offices, all obstetricians/gynecologists, and high-volume behavioral care practitioners.

    A prospective provider office on-site audit will be performed for all prospective PCPs, obstetrician/gynecologists, high-volume specialists, and high-volume behavioral health care practitioners. The visit will include a review of the medical record-keeping system and a structured physical site review.

Note: VCHCP's provider site review standards meet NCQA criteria which include an assessment of physical accessibility, language assistance capabilities, physical appearance, adequacy of waiting and examining room space and availability of appointments including expected performance standards.

Deficiencies discovered in the medical record audit are reported to the Credentialing Committee for recommendations and follow-up. The completed provider site audit evaluation form, including documentation of any recommendations and/or education, is shared with the provider and filed in the Credentialing Profile. The results of the audit, committee recommendations and follow up will be incorporated into credentialing and re-credentialing decisions.

11. Queries

Queries will be made with regard to disciplinary actions, restrictions, limitations, etc. The queries will be made of one or more of the following recognized monitoring organizations:

a. National Practitioner Data Bank (NPDB) (not required for chiropractors and podiatrists)
b. The Federation of State Medical Boards (FSMB) (physicians, osteopaths and dentists only)
c. The State Board of Dental Examiners (dentists only)
d. The Federation of Podiatric Medical Boards (podiatrist only)
e. The State Medical Board and the State Sanctions Agency
f. Sanction verification by Medicare and Medicaid.

Reviews for previous sanction activity by Medicare and Medicaid with the Office of the Inspector General, Health and Human Services Medicare and Medicaid Sanctions and Reinstatement Report, the cumulative sanctions report for non-Medicare contracting providers, the state Medicaid agency or intermediary and the Medicare intermediary, the Federal Employees Health Benefits Program debarment record published by the Office of Personnel Management, Office of the Inspector General or Federation of State Medical Boards.

12. Language Assistance

An attestation form must be filed and maintained by the VCHCP attesting to the language spoken, the applicable Provider or office staff, and must be maintained upon initial credentialing and recertified at time of recredentialing.

Section 3 – Physician Provider Responsibilities

Participation in the HEDIS Quality Measurement Process

"HEDIS", which stands for *"Health Care Effectiveness Data and Information Set"*, is an evolving set of measures designed to provide performance-related information in a standardized, objective, and useful format.

Developed by the National Committee for Quality Assurance (NCQA), HEDIS currently serves as an incentive for VCHCP and its provider network to improve its performance in providing access to high-quality care and service. VCHCP has been an advocate for health care quality measurement and has been participating in the HEDIS reporting process since 1998.

In order to report HEDIS statistics as accurately as possible, VCHCP conducts a rigorous search for all relevant medical information. The search begins with our administrative systems and then broadens to include a review of the members' medical records. It is in this aspect of the HEDIS reporting process that we need the assistance of our members' primary care physicians.

Medical record review is an integral part of the HEDIS reporting process. In order to conduct this review, a physician's office may be asked to:

- provide documentation indicating whether or not certain patients have had specific screenings or services
- allow a VCHCP professional services coordinator access to patient's medical records in order to abstract and photocopy the relevant data
- review medical records with a VCHCP healthcare representative in order to ensure correct interpretation of the progress notes

Whether data is obtained through encounter reporting, through claims, or through audits of your medical records, the accuracy and completeness of the data and your cooperation with the data collection efforts is vital to the quality improvement program.

Section 3 – Physician Provider Responsibilities

Confirmation of Good Standing with State and Federal Regulatory Agencies

All VCHCP-contracted physician providers must maintain a current license with the California Department of Health Care Services (DHCS). Providers must also maintain a current and valid medication prescription license from the DEA.

Evidence of Professional Liability Insurance

Each physician provider must maintain and provide evidence of professional liability insurance, including a copy of the certificate of insurance that states the name of the insured, the length and amount of coverage (as defined in the agreement), and the expiration date.

Section 3 – Physician Provider Responsibilities

Quality Management and Improvement

Our Quality Management Committee selects and oversees quality measurement and improvement activities according to our strategic goals and accreditation and regulatory requirements. Our efforts encompass a wide range of methods for monitoring and improving the clinical and non-clinical care and services for our members, including member satisfaction surveys, access and availability monitoring, chronic disease management, Continuity and Coordination of Care, and Health Care Effectiveness Data and Information Set (HEDIS®) measurement.

We gauge the effectiveness of our quality-related efforts by conducting ongoing systematic reviews, using tools and standards developed by a variety of agencies and organizations, including:

- National Committee for Quality Assurance (NCQA)
- Department of Managed Health Care (DMHC)
- Centers for Medicare and Medicaid Services (CMS)
- California Health and Safety Code

Section 3 – Physician Provider Responsibilities

Medical Records

To assist us in maintaining continuity of care, physician offices must provide medical records of services rendered to our members when it is essential to communicate the documentation of care to other providers and/or VCHCP for the purpose of delivering further care and/or making further care decisions.

Members are entitled to obtain copies of their own medical records, including copies of Emergency Department records, X-rays, CT scans, and MRIs. Hospitals must make member medical records available upon request within time requirements established by regulatory agencies, to the member and to VCHCP and its designated agents. Additionally, the hospital must, without charge, transmit a member's medical record information to the member's PCP and other providers, and to VCHCP for purposes of utilization management, quality improvement, and other VCHCP administrative purposes. The hospital also must secure from the member on admission a release of medical information, in the event it is required by law.

In keeping with regulatory standards, a member's medical records must be kept for at least six years after the last member contact.

State, Federal and VCHCP internal quality of care policies require that medical records be maintained in a manner that is current, detailed and organized, and permits effective and confidential patient care and quality review. Medical records should also be kept, at a minimum, in compliance with core elements to medical record documentation as defined by NCQA.

Please refer to **Appendix C** for VCHCP's complete policy on medical record-keeping.

Section 3 – Physician Provider Responsibilities

Confidentiality

State and federal laws regulate the release of individual's health and other personal information. VCHCP has implemented policies and procedures to protect and ensure the confidential treatment of personal and health information of our members and privileged medical record information. We expect that every physician provider will protect and maintain the confidentiality of VCHCP members' personal and health information in accordance with the law.

This means, in addition to other requirements, that all patient information and medical records, including clinical reports, must be otherwise protected from viewing by, and contact with, anyone not directly responsible for a member's care, or as otherwise required by regulatory, law enforcement, or government agencies.

In conformance with the Health Insurance Portability and Accountability Act ("HIPAA"), VCHCP has developed and makes available its policy and procedures with regard to compliance with Federal HIPAA requirements. A copy of this document is provided to new members and can be viewed on the plan's website as well.

Section 3 - Provider Responsibilities

Compliance with the Americans with Disabilities Act

The Americans with Disabilities Act (ADA) requires public accommodations (e.g., professional office of a health care provider, VCHCP, etc.) to provide goods and services to people with disabilities on an equal basis as people without disabilities. VCHCP and contracted health care providers must comply with the ADA, which applies equally to the physician practitioner, to the hospital and to health plans.

Providers are responsible for making reasonable accommodations available for disabled members and cannot pass on the cost of accommodating the patient's needs.

If a provider is unable to accommodate a disabled patient, the provider should arrange for the patient to be seen by a provider who is able to accommodate the member.

Section 3 - Provider Responsibilities

Primary Care Physician Responsibilities

Purpose

To establish the overall responsibilities of the Primary Care Physician (PCP) in the delivery of clinical services to the member.

To establish a system to support continuity of care for the member.

Scope

Established descriptions of PCP responsibilities may be reviewed, approved and utilized by VCHCP (e.g., Milliman's "Ambulatory Care Guidelines"). VCHCP, in conjunction with actively practicing local physicians, also may develop its own description of the Primary Care Physician responsibilities. The following example describes in general the role of the primary care physician:

1. The PCP serves both as a provider and coordinator of the member's care. The PCP provides medical expertise and direction concerning the member's healthcare needs–functioning as a manager for all healthcare services provided to the member.

2. The PCP provides, or arranges for, 24 hour/seven day per week coverage in his or her primary care practice.

3. PCPs are expected to provide services within their scope of duties and privileges, without referral to a specialist, unless such provision of care has been conducted without a significant improvement of the member's condition, or unless the PCP recognizes that further treatment or procedures are necessary, and can only be provided by a specialist or other consultant. Services rendered by the PCP include preventive services that are timely for children and adults: well-child care, immunizations, and health screenings.

4. The PCP receives and evaluates specialist reports and determines (with specialist provider input, when necessary) if additional specialty services are needed. This involvement of the PCP helps to ensure continuity of care and eliminates duplication of services.

5. The PCP submits authorization requests for medically necessary services to the UM Department for approval.

   Following authorization for a requested specialist, said specialist (as approved by the committee) may directly submit requests to the UM Department for approval.

6. During the member's hospitalization, stay in a skilled nursing facility or utilization of home healthcare services, the PCP continues to monitor the medical necessity of services being provided and facilitates the appropriate transfer of the member to a lower level of care. The facility attending physician may be responsible for monitoring the member's care.

Section 4 – Medical Management

Program Overview

VCHCP's Medical Management program is a collaborative process of assessment, planning, facilitation, advocacy, and implementation of options and services to meet an individual's health needs, to promote delivery of medically necessary, appropriate health care or services and quality, cost-effective clinical outcomes. The Medical Management Program is designed to assist VCHCP contracted physicians, providers, and hospitals in ensuring that medical services are:

- Covered under the member's health plan benefits
- Appropriate and medically necessary. The appropriateness of care and the medical necessity of services determination are made by qualified licensed health care professionals. Medically necessary services include only those services that have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness, injury, or medical condition. Medically necessary services also are:
    - Consistent with the symptoms or diagnosis
    - Not furnished primarily for the convenience of the patient, the attending physician, or other provider
    - Provided safely and effectively to the patient at the most appropriate level of care
    - Consistent with VCHCP's Medical Policy, as well as federal and state regulations
- Provided at the most appropriate level, consistent with the:
    - Accepted standards of medical practice
    - Patient's diagnosis and level of care required
    - Nationally recognized utilization management (UM) criteria, without undue influence of Plan management concerned with VCHCP's fiscal operations
    - Guidelines established by the VCHCP Medical Policy Committee and federal and state regulatory guidelines

The goal of VCHCP's medical management program is to promote the efficient and appropriate utilization of medical services and to monitor the quality of care given to members. To accomplish this goal, the program requires systematic monitoring and evaluation of the medical necessity and level of care of the services requested and provided. VCHCP determines medical necessity and the appropriateness of the level of care through the prospective review of care requested and the concurrent and retrospective review of care provided. These reviews are conducted by VCHCP nurse reviewers, medical directors, peer review committees, physician peer reviewers and other consultants.

VCHCP may also delegate UM activities to subcontracted entities. "Optum Health Behavioral Solutions" is one of those entities. VCHCP approval of the delegated entity's UM program is based on a review of its policies and procedures, demonstration of compliance with stated policies and procedures, and the ability to provide services to our members in keeping with various accreditation and regulatory requirements. All delegated activities are monitored and evaluated by the VCHCP medical management teams and the appropriate oversight committee to assist the delegated entity in improving its processes. VCHCP retains the authority and responsibility for the final determination in UM medical necessity decisions and ensures appeals related to utilization issues are handled in a timely and efficient manner.

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Program Functions

VCHCP has developed medical management processes that address inpatient and outpatient utilization, as well as monitor quality of care. Our medical management process includes, but is not limited to, the following functions:

- Pre-admission/elective admission authorization
- Pre-service review
- Emergency services review
- Transplant management, in conjunction with the Plan's Transplant Network administrator, Optum Health Transplant Care
- Utilization management(UM)/concurrent and retrospective review (post- service review)
- Medical management for continuity and coordination of care
- Claims review for service appropriateness
- Focused ambulatory care review
- Clinical support for grievances and appeals
- Quality review

Section 4 – Medical Management

Pre-Admission / Elective

The physician or hospital must obtain authorization for VCHCP hospital admissions from the Utilization Management (UM) department of the plan at least, preferably ***five business days prior*** to an elective admission.

The member's identification card indicates the appropriate telephone number for providers to call for pre-admission authorization.

The member's PCP is responsible for coordinating the member's care and ensuring that appropriate authorizations are obtained from VCHCP.

VCHCP members are also advised in their *Summary of Benefits and Evidence of Coverage* (EOC) that they are responsible for obtaining or assuring that their physicians (attending or specialist) obtain prior authorization from the Plan for specified services, as indicated in the EOC.

Note: Failure to obtain required pre-admission or admission review may result in partial or total benefit denial.

Section 4 – Medical Management

Ambulatory Surgeries / Procedures

VCHCP authorization is required for facility and office-based ambulatory surgeries/procedures.

Facility-based ambulatory surgeries/procedures are performed in an acute care facility on an outpatient basis or in a free-standing ambulatory surgery center. The Ventura County Medical Center ("VCMC") provides VCHCP members with the highest level of ambulatory surgical care and professionalism. Surgical diagnostic procedures are identified as facility-based ambulatory surgeries/procedures.

Minor ambulatory surgeries/procedures are generally performed in the physician's office setting. If it is medically necessary that they be performed in a facility setting, on an outpatient or inpatient basis, authorization by VCHCP Medical Management will be required.

Section 4 – Medical Management

Emergency Services

If a member needs emergency care, he or she is covered 24 hours a day, 7 days a week, anywhere in the world. An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and/or her unborn child.

Prior authorization is not required for urgent and emergency services. If these services result in a hospital admission, the attending physician or the hospital is required to notify the Plan within 24 hours or by the end of the first business day following the admission. The member should notify his or her primary care physician as soon as it is medically possible for the member to provide notice.

Weekend and holiday services that result in admissions require notification from the hospital by the next business day. The medical management team reviews the request for admission within five business days from receipt of request. Admissions are reviewed for medical necessity, level of care, appropriateness of care, and benefit determination. After the review is completed, the facility is notified of the determination by phone, fax and/or in writing within 24 hours of the decision. The hospital, member, and attending physician are also notified in writing of the determination, including the initial authorized length of stay or denial of the authorization request. If the member's condition is urgent, the facility is notified of the determination by phone, fax and/or in writing within 24 hours of the decision not to exceed 72 hours of receipt of request.

Follow-up Care After Emergencies

After Emergency or Urgent care services, follow-up care should be coordinated by the primary care physician. Follow-up care with non-participating providers is only covered with a referral from the primary care physician and pre-approval from VCHCP. Whether treated inside or outside VCHCP's service area, the member must obtain a referral before any follow-up care can be provided.

Section 4 – Medical Management

Transplant Coverage

Members referred for major organ transplants (including kidney when transplanted with another organ) are evaluated within VCHCP's Transplant Network program as administered by Optum Health Care. Certain transplants are eligible for coverage within VCHCP's transplant network, but only if specific criteria are met and prior written authorization is obtained from VCHCP's Medical Management Team. Donor costs for a member are only covered when the recipient is also a VCHCP member. Donor costs are paid in accordance with Medicare coverage guidelines.

Healthy Families Program members must be referred to a CCS transplant center for all transplant services including evaluation.

Note: Charges incurred as a result of cadaver organ donor evaluation, donor maintenance and organ recovery are directly reimbursable by the Organ Procurement Organization (OPO) according to Federal law and therefore are not paid by VCHCP. These charges may include but are not limited to: lab studies, ultrasound, maintaining oxygenation and circulation to vital organs, and the recovery surgery.

Authorizations for organ or non-organ transplants are required from VCHCP for transplant types such as the following:

- Bone marrow
- Stem cell
- Kidney
- Kidney and pancreas
- Heart
- Heart/lung
- Lung
- Liver
- Pancreas
- Small bowel with or without liver
- Multi-organ transplants (e.g., kidney and liver)

Section 4 – Medical Management

California's Health Services Program for Children with Serious Medical and Developmental Conditions

Program Description
A statewide program in California, known as "**California Children's Services" ("CCS"),** arranges, directs, and pays for medical care, equipment, and rehabilitation, for children with certain medical and developmental conditions.
Children with qualifying conditions are usually initially identified as potentially eligible for this program by the child's doctor. A child may be eligible if he or she meets all four of the following requirements:

1. Age – the child must be under 21 years of age.
2. Residence – the child must be a permanent resident of the California county where their parents apply.
3. Income – the family income must be less than $40,000 per year, according to the adjusted gross income reported on the parents California income taxes. A child may be eligible when the family income is more than $40,000 if medical care for the child's CCS condition is expected to cost the family more than 20 percent of the family's income. If the child is adopted, the family income may not matter.
4. Medical conditions – Only certain conditions are eligible for CCS. In general, CCS covers medical conditions that are physically disabling or require medical, surgical, or rehabilitative services. There also may be certain additional criteria used to determine if the child's medical condition is eligible.

Eligible Conditions
The CCS program defines eligibility and selects the most qualified professionals to treat the child's condition. It is important to know that CCS is not a health insurance program. It usually will not meet all of the child's health needs - only those related to the CCS-eligible condition. VCHCP remains responsible for the provision and cost of any other medically-necessary services not covered by the CCS program.

Some Common CCS-Eligible Conditions Are:

- Conditions involving the heart – (congenital heart disease, rheumatic heart disease)
- Neoplasms – (cancers, tumors)

- Diseases of the blood – (hemophilia, sickle cell anemia)
- Diseases of the respiratory system – (cystic fibrosis, chronic lung disease)
- Endocrine, nutritional, and metabolic diseases – (thyroid problems, PKU, or diabetes that is hard to control)
- Diseases of the genitor-urinary system – (serious kidney problems)
- Diseases of the gastrointestinal system – (liver problems, such as biliary atresia)
- Serious birth defects – (cleft lip/palate, spina bifida)
- Diseases of the sense organs – (eye problems leading to loss of vision such as glaucoma and cataracts, and hearing loss)
- Diseases of the nervous system – (cerebral palsy, uncontrolled epilepsy/seizures)
- Diseases of the musculoskeletal system and connective tissue – (rheumatoid arthritis, muscular dystrophy)
- Severe disorders of the immune system – (HIV infection)
- Disabling injuries and poisonings requiring intensive care or rehabilitation – (severe head, brain or spinal cord injuries and severe burns)
- Complications of premature birth requiring an intensive level of care
- Diseases of the skin and subcutaneous tissue – (severe hemangioma)
- Medically handicapping malocclusion – (severely crooked teeth)

Parents are advised by VCHCP to consult their child's doctor if they have any questions about whether or not their child has any of these conditions.

The list above is made up of common qualifying conditions. If you or your patient's parents have a question about additional eligible medical conditions, you can contact:

VENTURA COUNTY CHILDREN'S MEDICAL SERVICES (CMS)
2240 E Gonzales Rd, Ste 260 & 270
Oxnard, CA
(805) 981-5281

CCS & Other Health Insurance Coverage

If the child has health insurance coverage with the Healthy Families Program (HFP):

VCHCP contracts with the State of California to provide health care coverage to children enrolled in the Healthy Families Program (HFP). The HFP coordinates with CCS with to the eligible conditions discussed above. Although the HFP does not pay for services to fully diagnose or treat a CCS eligible medical condition, VCHCP may cover those costs. If the child is suspected of having a CCS eligible medical condition, he/she should be referred to a special CCS paneled provider who is experienced in diagnosing and treating the suspected eligible medical condition. Upon approval by CCS, the diagnosis and treatment services will be covered by the CCS program. CCS is a partner with the Healthy Families Program to provide the child with the specialized medical care needed to treat his/her CCS eligible medical condition. Patients must accept the CCS referral to a CCS paneled or approved provider in order to receive all the benefits of the CCS program. VCHCP remains responsible for providing the child's primary care, prevention and other treatment services not authorized by the CCS program.

If the child is covered by private health insurance:

A child may be eligible for the CCS program even though he/she has group coverage under a VCHCP commercial benefit plan. If the child becomes covered by CCS, and has individual or group health insurance coverage with VCHCP, the parent/guardian should report it to the county CCS office and to the child's health care provider. Private health insurance coverage can be used to help reduce CCS program costs.

Section 4 – Medical Management

Behavioral Health Services

VCHCP offers Behavioral Health services under a comprehensive program known as "Life Strategies". The *Life Strategies* program is administered by a Behavioral Health Services Administrator which coordinates the delivery of all mental health and substance abuse services through a unique network of contracted behavioral health providers.

The member may arrange for mental health and substance abuse services, without a referral from VCHCP or the member's PCP, by contacting the Life Strategies program directly at the phone number shown on the member's ID care. Visits for mental health and substance abuse services may accrue to a calendar maximum number of visits, depending on the member's benefit plan.

Section 4 – Medical Management

Admission and Concurrent Inpatient Review

VCHCP applies industry standard protocols and clinical care guidelines developed by a company known as “Milliman”, in the admission and concurrent review process. VCHCP Medical Management reviewers may conduct concurrent review throughout an admission to determine level of care and continued medical necessity. The reviews are conducted by telephone or on-site, as appropriate. Nurse reviewers evaluate medical necessity and appropriateness of the level of care, including sub-acute care, and may require supporting medical documentation from the hospital.

If the health plan medical director or physician reviewer determines that the services are not medically necessary or at the appropriate level of care, he/she will contact the attending physician to develop a mutually agreed-upon discharge plan. If a discharge plan cannot be agreed upon, concurrent review will continue until such time the attending physician agrees upon a discharge plan.

To complete the authorization process and enable timely claims payment, the patient's discharge date must be communicated to the Medical Management Team as soon as possible after the discharge. Additionally, VCHCP may require copies of part or all of the patient’s medical record for the Medical Management Team’s review.

Section 4 – Medical Management

Case Management

Case Management is a collaborative process of assessment, planning, facilitation and advocacy. Determination is made for the best options and services to meet a member's individual health needs through communication and utilization of available resources to promote quality care and cost-effective clinical outcomes.

Case Management is a process designed to more efficiently coordinate services, to provide a delivery methodology for targeted populations at risk, and to promote an interdisciplinary approach to meeting member needs throughout an episode of illness or continuum of care.

Complex Case Management is a process that includes elements of behavior change and self management with a goal to stabilize complex high intensity members and prevent adverse outcomes. VCHCP licensed healthcare professionals collaborate with members, families, and providers to evaluate the appropriateness of care in the most cost effective setting without compromise to quality care.

Section 4 – Medical Management

Medical Necessity Denials

The VCHCP Medical Director has overall responsibility for VCHCP's Medical Management Program. The Medical Director is responsible for Medical Management program implementation, and providing clinical expertise. A licensed physician reviews all medical necessity denials. Board-certified physicians from the appropriate specialty assist in making medical necessity determinations, if necessary.

When a hospital admission, continued stay, or proposed service is determined to be not medically necessary or not covered under the member's plan, the attending physician is notified by phone or fax within 24 hours of the decision. Written notification of the denial is also sent to the member or responsible party, the attending physician, and the hospital. Notification is within five business days of making the decision. For urgent requests, notification is within 24 hours of receipt of requests.

Section 4 – Medical Management

Quality of Care Assessment

VCHCP has a comprehensive review system to address quality-of-care concerns. This process may be initiated by contact from a member, member representative, internal staff or network provider.

Potential Quality of Care Issues (PQI's) involving clinical judgment are brought to the attention of VCHCP's Medical Director. Occasionally, through peer review, an evaluation or review of the performance of colleagues by professionals with similar types and degrees of experience may be made.

The plan's Quality of Care Nurse assists in the collection of records and composition of the clinical summary of findings and forwards the case for review. The VCHCP Medical Director will review supporting documentation and evaluate it for the existence of a quality-of-care issue. There may be requests to the provider for additional documentation and/or direct contact between the VCHCP Medical Director and the providers involved in the case. The Quality Management Department then prepares the case for Committee review.

Section 5 – Billing & Payment

Overview

In general, for VCHCP contracted providers, VCHCP follows Medicare guidelines for billing and payment. Please refer to your contract for additional information.

This section outlines our billing procedures and requirements for submitting claims. It also describes VCHCP claims payment policies for specific situations, such as coordination of benefits (COB), and explains VCHCP's process for resolving billing issues.

Claims Submission

Electronic Submission

Providers may submit their claims electronically through Office Ally, a claims clearinghouse, for no charge. For information regarding how to contact Office Ally, you may call the VCHCP Member/Provider Services Department at (805) 981-5050, contact Office Ally directly at (866) 575-4120, or visit their website at info@officeally.com or www.officeally.com

Refer to the HIPAA ANSI Implementation Guide and California 837 Transaction Companion Guide for the specific regulatory requirements for submitting claims electronically.

Paper Submission

In order for the Plan to process paper claims quickly, accurately, and efficiently, providers should submit a properly completed “Centers for Medicare and Medicaid (CMS) 1500 Form or its successor as adopted by the National Uniform Claim Committee (NUCC). Please send claims to:

VCHCP
Claims Processing Dept.
2220 E. Gonzales Rd. #210-B
Oxnard, CA 93036

Section 5 – Billing & Payment

Reference Materials

Reference materials are available to ensure appropriate coding. Various types of codes used in submitting claims are listed below.

ICD-9-CM (International Classification of Diseases) Codes
Used to identify diagnoses and procedures. The diagnostic codes are three-digit codes with one or two-digit subcategories, and the procedure codes are two-digit codes with one or two-digit subcategories. Precise coding with appropriate subcategories is essential to present a clear clinical picture of the patient's condition.

ICD-10-CM (International Classification of Diseases) Codes

The Plan is not currently accepting or processing claims billed with ICD-10-CM codes. However, VCHCP will be transitioning to the usage of these codes on October 1, 2014, to meet the U.S. healthcare industry's most recently published implementation date.

CPT (Current Procedural Terminology) Codes
Five-digit codes for identifying medical services and procedures performed by physicians are also required for billing certain outpatient and inpatient services on the institutional UB-04 CMS 1450 Form (for example, billing outpatient surgery under revenue code 360). If applicable, two-digit (or two-character) modifiers should be included in addition to the five-digit CPT code to report that a service or procedure has been altered or modified by some specific circumstance without altering or modifying the basic definition or CPT code. The American Medical Association publishes the CPT code manual. Use this resource when billing for the following types of services:

- Surgical procedures
- Radiological/pathological/diagnostic tests
- Patient visit (rendered in office, emergency room, hospital or other facility setting)

Anesthesia CPT Codes

ASA Guide (American Society of Anesthesiologists' Relative Value Guide) Coding
These five-digit CPT codes used to bill for anesthesia services must include modifiers to identify the patient's physical status. Time units (15 minute = 1 unit) are also added to the basic value. Be sure to bill minutes for electronic submissions. For complete details on coding, please refer to the latest version of the ASA Relative Value Guide.

HCPCS (HealthCare Procedure Coding System)

HCPCS (Health Care Procedure Coding System) National Level II, published by the AMA, is a listing of codes and descriptive terminology used for reporting the provision of supplies, materials, injections, and certain services and procedures. If applicable, two-character modifiers should be included in addition to the HCPCS to report that a service or procedure performed has been altered by some specific circumstance, but not changed in its definition or code. (For example, a modifier could be used to indicate whether Durable Medical Equipment was rented or purchased.)

Average Wholesale Price (AWP):

AWP refers to the average wholesale price of the pharmaceuticals dispensed per National Drug Code (NDC) code, based upon provider's purchased package size, as set forth in a nationally recognized pricing source such as First Data Bank and its supplements or other such sources, as determined by VCHCP. *For new drugs or drugs that are unclassified, Provider must bill using the appropriate revenue code, unclassified J Code (HCPCS) with description in order to receive payment.*

Section 5 – Billing & Payment

Claim Attachments

Detail of Charges

Occasionally, VCHCP may ask you to provide an itemization of charges (e.g., exception claims). In those instances, your prompt cooperation will expedite the payment process.

Coordination of Benefits (COB) Documentation

When VCHCP is the patient's secondary carrier, attach proof of the primary carrier's payment or denial and a copy of the other carrier's identification card (see Coordination of Benefits information further in this manual).

Section 5 – Billing & Payment

Workers' Compensation

If the Workers' Compensation carrier has not already accepted the case as work related, and is not yet providing coverage, then when a member is injured or an illness arises out of, or in the course of, any employment for salary, wage or profit, and the medical expenses incurred are covered by any workers' compensation law, occupational disease law or similar legislation, VCHCP and/or the provider may assert a lien to the extent permissible by law.

If applicable, VCHCP and/or the provider should:

1. Provide covered services;
2. Reimburse referral providers;
3. Investigate for possible workers' compensation liability;
4. Obtain the consent of the member to pursue reimbursement rights to the extent permissible under the law.

Section 5 – Billing & Payment

Coordination of Benefits (COB)

Coordination of Benefits (COB) is a provision used to address instances when a member is covered by more than one group health plan. In California, COB is regulated by state law.

Health plans, like VCHCP, which have COB provisions in their contracts with providers are required to make those provisions consistent with the standard provision set forth in subdivision (b) of Section 1300.67.13 of the California Code of Regulations (CCRs).

Additionally, the National Association of Insurance Commissioners (NAIC) has developed model COB regulations, which have been adopted by California.

COB ensures that:

- benefits paid by multiple group health plans do not exceed 100 percent of eligible expenses, and
- there is no duplication of benefits, and
- there is a consistent order of payment when a member has multiple group health plans, and
- coverage is provided to the member without considering the existence of any other plan.

Please refer to Appendix D for a complete discussion of the rules relating to COB.

Section 5 – Billing & Payment

Timely Submission of Claims and Appeals

Claims appeals by providers must be in writing and must specify the basis for the appeal. Particular payment or procedural issues that are in question must be cited. Unless otherwise specified in your contract, the following time frames for submission of claims and appeals will apply:

- New claims: within 180 calendar days from the last date of service or the time specified in your contract, whichever is greater.
- Claims requiring coordination of benefits with another carrier: within 180 days of the primary carrier's payment determination.
- Initial Appeals: within 365 calendar days of the last VCHCP payment or decision, or the time frame specified your contract, whichever is greater.
- Final Appeals: within 65 business days of VCHCP's initial determination, or the time specified in your contract, whichever is greater.

Note: VCHCP will deny any claims or appeals that are not submitted within these time frames.

Section 5 – Billing & Payment

Provider Appeals and Dispute Resolution

As of January 1, 2004, in response to state regulations, VCHCP has established fair, fast and cost-effective procedures to process and resolve Provider Appeals. VCHCP's Provider Dispute Resolution Process is accessible to both contracting and non-contracting providers.

Definitions & Procedures

Appeal
A written notice to VCHCP challenging, appealing or requesting reconsideration of a claim, or requesting resolution of billing determinations, such as bundling/unbundling of claims/procedures codes or allowances, or disputing administrative policies & procedures, administrative terminations, retroactive contracting, or any other contract issue.

Bundled Appeal
A written notice identifying a group of substantially similar multiple claims that are individually numbered using the VCHCP assigned Internal Control Number (ICN) to identify each claim contained in the bundled appeal; or a written notice, submitted to the designated Provider Appeal addressed, identifying a group of substantially similar contractual Appeals that are individually numbered using the section of the contract and sequential numbers that are cross-referenced to a document or spreadsheet. (For example, 'Section I A #1, Section I A #2', etc.)

Provider Inquiry
A telephone or written request for information, or question, regarding claim status, submission of corrected claims, member eligibility, payment methodology rules (logic, bundling/unbundling logic, multiple surgery rules), Medical Policy, coordination of benefits, or third party liability/workers compensation issues submitted by a provider to VCHCP, or a telephone discussion or written statement questioning with the way VCHCP processed a claim (i.e. wrong units of service, wrong date of service, clarification of payment calculation)

Receipt Date
The working day when the Provider Appeal is first delivered to the Plan.

Appeal Determination Date
The date VCHCP's written determination in response to a Provider Appeal is deposited in the U.S. Mail or faxed to the provider's office.

Date of Contest, denial, notice, or payment
The date VCHCP's claim decision, or payment, is electronically transmitted or deposited in the U.S. mail.

Unjust or unfair payment pattern
Any practice, policy or procedure that results in repeated delays in the processing and/or in the correct reimbursement of claims as defined by applicable regulations.

Unfair billing pattern
Engaging in a demonstrable and unjust pattern of bundling/unbundling or up-coding of claims, and/or other demonstrable and unjustified billing patterns.

Good cause for untimely submission of claims
Circumstances reasonably beyond the control of the provider that prevented the timely submission of a claim would be considered 'good cause'. Examples of circumstances beyond the control of the provider, include, but are not limited to:

- patient gave incorrect health coverage/insurance information (copy of an incorrect ID card);
- patient was unable to provide health coverage/insurance information (patient was comatose, the patient expired before the information could be obtained, etc.);
- natural disaster/acts of nature (fire, flood, earthquake, etc.);
- acts of war/terrorism;
- system wide loss of computer data (system crash).

Examples of circumstances that do not constitute 'good cause':

- claim was sent to the wrong carrier (Blue Cross instead of VCHCP), but the provider had the correct health coverage/insurance information;
- the claim was submitted timely, but VCHCP was unable to process because the claim was not a complete claim (did not contain the minimum data elements to enter the claim into the system, i.e., missing a subscriber number).

Providers have an obligation to be responsible for appropriate timely billing practices. Provider requests to review a claim timely filing denial because the provider believes there was good cause for the delay, will be handled as a Provider Appeal.

Reporting unfair billing pattern
VCHCP may report providers who VCHCP believes are engaging in unjust billing patterns to the DMHC toll-free provider line **(877) 525-1295** or email address, plans-providers@dmhc.ca.gov

Reporting of unfair payment patterns
Providers may report instances in which the provider believes a plan is engaging in an unfair payment pattern to the DMHC's Office of Plan and Provider Relations. Toll-free provider line **(877) 525-1295** email address plans-providers@dmhc.ca.gov.

Unfair payment pattern
Unjust payment patterns:

- Imposing a claims filing deadline, on three (3) or more claims over the course of any three-month period, or less than 90 days for contracting providers; 180 days for non-contracting provider; 90 days from the primary payers determination, when paying as a secondary/tertiary payer
- Failing to forward at least 95% of misdirected, capitated claims to the appropriate capitated entity within 10 business days of receipt, over the course of any three-month period
- Failing to accept at least 95% of late claim submissions, over the course of any three-month period, when the provider submits proof of Good Cause
- Failing to notify providers at least 95% of the time, in writing and within 365 days of the payment date of our intent to recover an overpayment over the course of any three-month period
- Failing to notify providers, at least 95% of the time over the course of any three-month period, of the claim, name of the patient, date of service and a clear explanation of the basis upon which an overpayment was made.
- Failing to allow providers 30 business days, at least 95% of the time over the course of any three-month period, of their right to appeal a request to recover an overpayment
- Failing to acknowledge at least 95% of claims within 2 business days for electronic submissions, or 15 business days for paper submissions
- Failing to provide an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim at least 95% of the time over any three-month period
- Including provider contract provision inconsistent with any of the applicable regulations of the Health and Safety Code or CCR, title 28 on three (3) or more occasions over the course of any three-month period
- Requesting medical records on more than 3% of claims, excluding professional emergency services and care claims, over the course of any 12-month period
- Requesting medical records on professional emergency services and care claims on more than 20% of the claims, over the course of any 12-month period

- Failing to process HMO claims within 45 business days at least 95% of the time over the course of any three-month period
- Failing to automatically pay interest penalties when processing exceeds the specified time frames at least 95% of the time over the course of any three-month period
- Failing to notify providers of the appeal process when a claim is denied, adjusted or contested at least 95% of the time over the course of any three-month period
- Failing to acknowledge initial provider appeals within 15 business days of receipt at least 95% of the time over the course of any three-month time period
- Failing to resolve and provide written determination of initial provider appeals within 45 business days of receipt
- Rescinding or modifying an authorization for health care services after the provider has rendered the service on three or more occasions over the course of any three-month period

Provider Contracts
VCHCP informs contracting providers initially upon contracting, or upon change of the Provider Appeal Resolution Process, of the procedures for submitting a Provider Appeal, including:

- Identity of the office responsible for receiving and resolving Provider Appeals
- Mailing address
- Telephone number
- Directions for filing an Appeal
- Directions for filing bundled Appeal
- The timeframe in which VCHCP will acknowledge receipt of the Appeal.

Explanation of Benefits
Explanations of Benefits (EOB) inform providers of the availability of VCHCP's Provider Appeal Resolution Process and provide instructions for filing a Provider Appeal. An EOB is sent each time VCHCP processes a provider submitted claim. EOBs are issued to both contracting and non-contracting providers.

VCHCP's Appeal process
The following information outlines the process VCHCP has established to allow providers to submit Appeals.

VCHCP's Provider Services Department is responsible for the Provider Appeal Resolution Process.

VCHCP's Senior Management is responsible for:

- The maintenance of the Provider Dispute Resolution Process;
- Review of the Provider Dispute Resolution operations.
- Noting any emerging patterns to improve administrative capacity, VCHCP Provider Relations, claim payment procedures and patient care;
- Preparing the required reports and disclosures.

Provider Appeals - reports
VCHCP will track each Provider Appeal and will report the following information in the Annual Plan Claims Payment and Dispute Resolution Mechanism Report:

- Information on the number and type of Provider Appeals received.
- A summary of the disposition of all Provider Appeals, including a description of the types, terms and resolution.

Internally, VCHCP will review the Provider Appeal data to identify emerging patterns and trends, and initiate the appropriate action.

Levels
VCHCP's Provider Appeal Resolution Process consists of two levels: Initial and Final.

CCR, title 28, Section 1300.71.38 requires health plans to offer an appeal process. State law does not require health plans to offer two levels.

Address for submission of an initial appeal
Initial Appeals must be submitted in writing to the following address:

Ventura County Health Care Plan
Appeal Resolution Office
2220 E. Gonzales Road, Suite 210-B
Oxnard, CA 93036

Required Information/Appeal
An Appeal must be submitted in writing and contain the following information:

- The provider's name
- The provider's identification number - the VCHCP provider identification number (PIN) and/or the provider's EIN.
- Contact information - mailing address and phone number
- The patient's name, when applicable
- The patient's VCHCP member number, when applicable

- The date of service, when applicable
- A clear explanation of the issue the provider believes to be incorrect. Supporting documentation (including medical records) should be included when applicable.

Appeals submitted with incomplete information
Appeals that are lacking the required information will be returned to the provider.

VCHCP will return the Appeal and notify the provider of the missing information necessary to categorize the submission as a Provider Appeal.

The original Appeal, along with the additional information identified by VCHCP, should be resubmitted to VCHCP within 30 business days of the provider's receipt of the notice requesting the missing information.

VCHCP will not require the provider to resubmit claim information or supporting documentation that has been previously received as part of the claims adjudication process.

Timeframe for submitting appeal
Initial Appeals must be submitted within 365 days, or the time specified in the provider's contract, whichever is greater, of VCHCP's date of contest, denial, notice or payment.

In the event the Appeal is regarding the lack of a decision, the Appeal must be submitted within 365 days, or the time specified in the provider's contract, whichever is greater, after the time for contesting or denying a claim has expired.

Appeals alleging a demonstrable and unfair payment pattern by VCHCP must be submitted within the timeframes indicated above, based on the date of the most recent action or inaction by VCHCP.

Timely filing of appeals
If a contracted provider fails to submit an Initial Appeal or Final Appeal within the required timeframes, the provider:

- Waives the right for any remedies to pursue the matter further
- May not initiate a demand for arbitration or other legal action against VCHCP
- May not pursue additional payment from the member.

In instances where the provider's contract specifies timeframes that are greater than the timeframes stipulated in VCHCP's Provider Appeal Resolution process, the provider's contract takes precedence.

Timeframe for providers to contest VCHCP's request to refund an overpayment
Providers must submit notice contesting VCHCP's refund request within 30 business days of the receipt of the notice of overpayment.

The provider's notice contesting VCHCP's refund request must include the required information for submitting an appeal as well as a clear statement indicating why the provider believes that the claim was not over paid. A provider's notice that it is contesting VCHCP's refund request will be identified as an Appeal and handled in accordance with VCHCP's Provider Appeal Resolution Process.

Timeframe for acknowledgement of Appeals
VCHCP will acknowledge the receipt of each Appeal within 15 business days of the receipt of the written Appeal.

Timeframe for resolving Appeals
VCHCP will resolve Appeals within 45 business days of the receipt of the Appeal.

In the event the original Appeal was returned to the provider due to missing information, the amended Appeal will be resolved within 45 business days of the receipt of the amended Appeal.

If the resolution of the Appeal results in additional monies due to the provider, VCHCP will issue payment, including interest when applicable, within 5 business days of the date of the written response notifying the provider of the Appeal resolution.

Resolution
VCHCP will provide a written determination to each Appeal, stating the pertinent facts and explaining the reason(s) for the determination.

The written determination of an initial Appeal will notify providers of their right to file a Final Appeal.

Submitting Appeals on a member's behalf
Appeals submitted on a member's behalf will be treated as a member grievance and handled within the member grievance process. VCHCP will verify with the member that the provider has been authorized to submit an Appeal (member grievance) on the member's behalf.

Final Appeals
Providers that disagree with VCHCP's written determination may pursue the matter further by initiating a Final Appeal.

To initiate a Final Appeal, providers must, within 65 business days of VCHCP's initial determination, or the time specified in the provider's contract, whichever is greater, submit a written request to the following address

Ventura County Health Care Plan
Appeal Resolution Office
2220 E. Gonzales Road, Suite 210-B
Oxnard, CA 93036

The Final Appeal must be submitted in accordance with the required information for an Appeal.

VCHCP will, within 45 business days of receipt, review the Final Appeal and respond in writing, stating the pertinent facts and explaining the reason(s) for the determination.

Arbitration
If, after participating in the initial and Final levels of the Appeal Resolution Process, the provider continues to disagree with VCHCP's payment or determination, the provider entity may submit the matter to binding arbitration as applicable and as outlined in the provider's contract.

APPENDIX A

GUIDELINES FOR TIMELY ACCESS TO NON-EMERGENT SERVICES

In 2010 the California Department of Managed Health Care (DMHC) finalized regulations that became effective on January 18, 2011 and require health plan patients to be seen by their providers in a timely manner. The primary intent of these regulations and the underlying legislation is to ensure that health plan enrollees have access to needed health care services in a timely manner. To accomplish this, the regulations require HMOs such as VCHCP to ensure that their networks of providers have the capacity and availability to provide care to enrollees within certain timeframes for various levels of care.

There are several terms contained in the legislation that providers and insurers need to be familiar with, including the following:

"Advanced access" means the provision of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or next business day.

"Appointment waiting time" means the time from the initial request for health care services by an enrollee or the enrollee's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers.

"Preventive care" means health care provided for prevention and early detection of disease, illness, injury or other health condition.

"Triage" or "screening" means the assessment of an enrollee's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care.

"Urgent care" means health care for a condition which requires prompt attention, consistent with subsection (h)(2) of Section 1367.01 of the Act.

These regulations require each plan to ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes for non-emergency services:

TYPE OF SERVICE	ROUTINE CARE	URGENT CARE	
	With or Without Prior Auth	Prior Auth **NOT** Required	Prior Auth Required
Primary Care	10 business days	48 hours	96 hours
Specialist Care	15 business days	48 hours	96 hours
Ancillary Services	15 business days	48 hours	96 hours
Mental Health	10 business days	48 hours	96 hours

Note: When it is necessary for a provider or an enrollee to reschedule an appointment, the appointment is required to be "promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice". Appointments for follow-up care are required to be scheduled according to the same standards as initial appointments.

Appendix B

MEMBER GRIEVANCES, COMPLAINTS AND VCHCP's APPEAL PROCESS

Purpose and Scope

VCHCP has developed its grievance/complaint and appeal system so that it provides reasonable procedures that ensure adequate consideration of our members' grievances/complaints and appeals in accordance with statutory requirements.

VCHCP members are entitled to have their grievances/complaints and appeals heard through a grievance and appeals process and have a contractual right to arbitrate issues that are not resolved to the member's satisfaction. Our grievance/complaints and appeal process shall provide for the receipt, handling and resolution of grievances/complaints and appeals within thirty (30) calendar days of receipt of the grievance by the Plan.

Grievances/complaints are about such things as quality of care, access to care, or delay in referral. Appeals are requests to reconsider an initial determination that denies coverage, for example, denial of a claim, denial of benefits, or other denial of coverage for a service.

The fact that a member submits a grievance/complaint or appeal to VCHCP will not affect in any way the manner in which the member is treated by VCHCP or receives services from contracting providers. If VCHCP discovers that any improper action has been taken against such a member, immediate steps will be taken to rectify the situation and prevent such conduct in the future.

Members are encouraged to review VCHCP's benefits and exclusions carefully prior to selecting our benefit plan for their health care needs. Certain health care services, for example, purely cosmetic surgery, are not covered benefits of the Plan. Services, medications, devices, or procedures that do not represent approved medical practices are also excluded from coverage by VCHCP. All such determinations for coverage are made by the Plan.

A member with a life threatening or seriously debilitating condition who disagrees with a VCHCP denial of coverage for a service, medication, device, or procedure is entitled to an expedited review under the Department of Managed Health Care's (DMHC) "Independent Medical Review" (IMR) process. The member may also request a face-to-face meeting with the VCHCP Medical Director to discuss the case.

Interface to the Plan's Quality Assurance Process

In order to evaluate opportunities for administrative practice improvements, referral process improvements, and educational opportunities for members and physicians, VCHCP collects and analyzes member satisfaction information, including, but not limited to, appeals and grievance/complaint data. VCHCP reports the results of these evaluations to the Quality Assurance and the Standing Committees, either of which may make recommendations for change based on these results.

Application

None of the information presented in this policy pertains to provider dispute resolution (this falls under the PDRM process).

Definitions

Grievance/Complaint: A grievance/complaint means a written or oral expression of dissatisfaction regarding the Plan and/or a provider. Where the Plan cannot distinguish between a grievance/complaint and an inquiry, the Plan will consider the inquiry to be a grievance/complaint.

Grievances/Complaints may include concerns about such things as quality of care, access to care, and delay, denial or modification of health care services.

Appeals: Any oral or written requests made by a member to reconsider an initial determination. The member or a representative of the member may file appeals. Appeals may include a denial of claims, denial of benefit, or other denial of coverage for service.

Expedited Review: When there is a time sensitive situation for cases involving an imminent and serious threat to the health of the member, including, but not limited to severe pain, potential loss of life, limb, or major bodily function.

Resolved: Grievance/complaint or appeal has reached a final conclusion (no pending Member appeals) with respect to the Member's grievance.

Policy

The grievance/complaint and appeal system has the following attributes:

- Grievance/Complaint and Appeal system in writing and addressed in the Members written materials, inclusive of website access.
- A grievance/complaint means a written or oral expression of dissatisfaction regarding the plan and/or provider.
- A grievance/complaint includes, but is not limited to, quality of care concerns, and complaint, dispute, request for reconsideration or appeal made by a member or the member's representative.

- Where the Plan cannot distinguish between a grievance/complaint and an inquiry, the Plan will consider the inquiry a grievance/complaint.
- Members are notified of the Plan's grievance/complaint procedures for filing and resolving grievances/complaints.
- Information supplied which includes the Plan's local and toll-free number; access to telephone relay systems; notification of linguist services and cultural assistance.
- Information supplied which includes the DMHC's review process, the Independent Medical Review System and the DMHC's toll-free telephone number and website address.
- Procedures are in place to receive, review and resolve grievances/complaints and appeals within 30 calendar days of receipt by the Plan.
- The Plan's grievance/complaint system allows Members to file grievances for up to six months (180 calendar days) following any event or action that is subject to the Member's dissatisfaction.
- Procedures are in place to elevate grievances/complaints for all urgent care needs, including quality of care needs; inclusive of 24/7 access to the Medical Director on Call for the Plan and the Administrative Officer on Call for the Plan. Both have the authority to approve medical care for the Plan.
- Written records of grievances/complaints and appeals are maintained by the Plan for no less than five years.
- Written records of grievances/complaints, summary of process, and summary of disposition and outcomes are reviewed by the Plan's Quality Assurance Committee and the Standing Committee.
- The Service Administrator of the Plan has been designated as having primary responsibility for the Plan's grievance system, inclusive of monitoring and reviewing, and identifying and reporting procedures in order to improve Plan policies and Procedures.

Procedures

1. VCHCP has established and maintains a grievance system under which enrollees may submit complaints to the Plan. The system is in writing and addressed in the Members' written materials, inclusive of website access. Members are notified upon enrollment of the process and annually thereafter. A member's legal guardian, conservator, or relative may submit grievances on the member's behalf to the Plan and/or the DMHC.
2. Where VCHCP is unable to distinguish between grievances/complaints and inquiries, they are considered grievance/complaints.

3. The system provides for the acknowledgement of the receipt of a grievance/complaint, notice to the grievant/complainant of who may be contacted with respect to the complaint within five (5) days, and for notice and/or a written statement to the complainant of the disposition of the complaint within 30 days of the Plan's receipt of the complaint.
4. For those grievances/complaints that can be resolved within five days or less of receipt, the written acknowledgment to the complainant of the resolution will stand as the receipt of notification and resolution.
5. VCHCP will inform members upon enrollment and annually thereafter of the process for resolving complaints: this information includes the location and telephone number where complaints can be submitted; access to telephone relay systems; notification of linguist services and cultural assistance; DMHC's toll-free telephone number and website address.
6. VCHCP provides members with written responses to complaints. Responses are to include a clear and concise explanation of the reasons for our response.
    - Grievances involving the delay, denial, or modification of services based on a determination that the service is not medically necessary**:** for grievances involving these issues VCHCP will, in its written notification of decisions to delay, modify, or deny service sent to the Member and the Provider, clearly state the criteria, benefits provisions, clinical guidelines or medical policies used in reaching said determination. Written notification (TAR) to the Member shall include notification to the Member of DMHC Consumer Assistance with the availability of an Independent Medical Review (IMR) by DMHC.
    - Grievances involving a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under our Plan contract: for grievances involving these issues, VCHCP, in its written response, will clearly specify the provisions in the Evidence of Coverage that exclude that coverage.
7. Members are made aware that after either completing the grievance process, or participating in the process for at least 30 days, they may submit the grievance to the DMHC for review.
8. Members are advised that they do not need to complete the 30-day process if the case involves an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function.
9. When appropriate VCHCP will bring complaints to the attention of providers, request appropriate corrective actions from them, and follow-up to see that necessary changes have been implemented.
10. The Plan maintains an automated Action Log which includes:
    - Date grievance/appeal/complaint identified to Plan
    - Action Log #, as identified by the system

- Actions, dates of actions, and who handled the action, in reference to resolution of complaint
- Date Acknowledgement Letter sent
- Date Interim Notification to the Member, if applicable
- Type of Complaint (Issue)
- Date Response Notification to the Member

11. The Plan also maintains a Member Grievance/Appeal/Complaints Log, which supplements the Plan's Action Logs. Member Grievance/Appeal/Complaints Log includes:
    - Date grievance/appeal/complaint identified to Plan
    - Action Log #, as identified by the Plan's MIS
    - Date Acknowledgement Letter sent
    - Date Interim Notification to the Member
    - Type of Complaint (Issue)
    - IMR Case identifier
    - Date Response Notification to the Member
12. Concurrent reviews of the MIS Action Log and Member Grievance/Appeal/Complaints Log are supervised by the Member Services Liaison for completion and updating.
13. Monthly review of the MIS Action Log and Member Grievance/Appeal/Complaints Log is supervised by the Service Administrator for purposes of committee reporting and tracking and trending. The Service Administrator is responsible for documenting and tracking the content and timing of the grievance and appeal process.

Expedited Review of Grievances

An expedited review is warranted when there is a time sensitive situation for cases involving an imminent and serious threat to the health of the member, including, but not limited to severe pain, potential loss of life, limb, or major bodily function.

1. VCHCP immediately notifies the complainant of his/her right to notify the DMHC of the grievance.
2. Expedited reviews include grievances for experimental procedures for the terminally ill.
3. All expedited reviews must be processed within three days (72 hours) from the time the request was received by VCHCP.
4. The member's medical condition shall be considered when determining the response time.

5. An extension of up to 10 additional business days beyond the 72 hours is possible if the extension of time benefits the member, such as allowing for additional diagnostic tests or consultations.
6. An extension can also be provided if the member requests additional time in order to supply VCHCP with additional information for making a decision.
7. If a non-contracting physician requests the grievance, the time frame begins only when the medical information necessary for making the determination has been communicated (orally or in writing) by the non-contracting physician to VCHCP.
8. VCHCP's procedures provide for receipt of Department contacts regarding urgent grievances twenty-four hours a day, seven days a week. VCHCP's Medical Director on Call and the Administrative Officer on Call have the authority to make decisions in these matters.

Use of Arbitration

1. Members may submit any dispute not settled by VCHCP to the member's satisfaction to the American Arbitration Association (AAA).
2. All parties involved in arbitration proceedings share equally in payment of the AAA administrative fee and arbitrator's fee, unless otherwise decided by the arbitrator. The party initiating the arbitration advances the administrative fee. The initiating party may recover the cost of filing the arbitration in the arbitrator's final apportionment of the awards. The arbitrator's award is binding and may be enforced by filing a petition for enforcement in any court having jurisdiction.
3. Regardless of the above, in the event of extreme financial hardship, the member's share of fees and expenses of the arbitrator may be assumed by VCHCP. An application and instructions on this process may be obtained by contacting AAA.

Reporting and Tracking Grievance/Complaints and Appeals

Internal Reporting

1. VCHCP maintains a written record of all grievances received either orally or in writing from members.
2. The written record, at a minimum, includes the date, identification of the member, identification of the individual recording the grievance (if different than the member), the Plan staff who initiated the record, Plan staff who reviewed and/or resolved the issues, actions taken to resolve the issue(s), and the disposition(s) of the resolution(s), inclusive of dates, and record of 5-day notification, interim notification, and 30 day resolution response.

3. Grievances/complaints and appeals are assigned a severity rating, regardless of how they are received, to ensure all complaints/grievances and appeals are addressed consistently and elevated expediently to appropriate professionally licensed clinical staff. (See Member Grievance and Appeal Process Severity Coding Policy).
    - Level 1: Minor inquiry or service level concern
    - Level 2: Moderate inquiry or service level concern or PQI
    - Level 3: Serious service level concern or PQI
    - Level 4: Very Serious and/or Sentinel Event
4. VCHCP's grievance system includes a system of aging grievances that are pending and unresolved for 30 days or more and summary reports in various categories for tracking and trending data analysis.
    - The Plan maintains an Action Log, which includes:
    - Date grievance/appeal/complaint identified to Plan
    - Action Log #, as identified by the Plan's MIS
    - Actions, dates of actions, and who handled the action, in reference to resolution of complaint
    - Date Acknowledgement Letter sent
    - Date Interim Notification to the Member, if applicable
    - Type of Complaint (Issue)
    - Date Response Notification to the Member
5. The Plan also maintains a Member Grievance/Appeal/Complaints (Tracking) Log, which supplements the Plan's MIS Action Logs. Member Grievance/Appeal/Complaints (Tracking) Log includes:
    - Date grievance/appeal/complaint identified to Plan
    - Action Log #, as identified by the Plan's MIS
    - Date Acknowledgement Letter sent
    - Date Interim Notification to the Member
    - Type of Complaint (Issue)
    - IMR Case identifier
    - Date Response Notification to the Member

6. A written record of tabulated grievances, summary of process, and summary of disposition and outcomes are periodically reviewed by the Quality Assurance Committee and the Standing Committee (a joint governing body and public policy participation committee).

External Reporting

VCHCP also provides the Department of Managed Health Care ("DMHC) with a quarterly report of grievances pending and unresolved for 30 or more days within the Plan's grievance system.

1. The report shall not include complaints filed outside the Plan's grievance system in other complaint resolution procedures.
2. The quarterly report shall be prepared for the quarter ending on March 31st, June 30th, September 30th, and December 31st of each calendar year.
3. The quarterly report shall not include personal or confidential information with respect to any enrollee.
4. The Plan's Service Administrator and Insurance Services Administrator are authorized to sign the report.
5. The quarterly report shall have separate categories of grievances by product line (Commercial, etc.) (include any complaint data for members of our state-sponsored programs [HFP & AIM] in the "Other" category).
6. For each of the complaints identified in the quarterly report VCHCP shall include a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more.

Record Retention

1. VCHCP will retain copies of grievances, the responses, and all other relevant information for a period of five years.
2. Copies of information that the Plan is required to maintain for five years shall include a copy of all medical records, documents, evidence of coverage, and other relevant information upon which the Plan relied to reach its decision.

DMHC Consumer Assistance

1. The DMHC maintains a program that assists consumers with resolution of problems and complaints involving HMOs. Members are advised of the following in 12-point bold type in their Evidence of Coverage (EOC), on the VCHCP five-day (Acknowledgment Letter) notification correspondence, disposition correspondence (Interim/Response or 30-day Letter), and in notices relating to denial of services (TARs) or appeals.

"The 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 805 981-5050 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), 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-hmo-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site (http://www.hmohelp.ca.gov) has complaint forms, IMR application forms, and instructions online."

2. Members are expected to use the HMO's appeal procedures first to attempt to resolve any dissatisfaction. If the appeal has been unresolved for more than 30 days or was not satisfactorily resolved by the plan, the member may seek assistance from DMHC.
3. If the grievance involves an immediate and serious threat to the member's health, the member may seek immediate assistance from DMHC.
4. Providers, including participating and non-participating physicians, may assist the member in submitting a complaint to the DMHC for resolution and may advocate the member's cause before the DMHC. No provider may be sanctioned by VCHCP for giving such assistance to a member.
5. The DMHC has 30 days from receipt of an IMR request to send the member and VCHCP a written notice of its determination (which the DMHC refers to as the notice of "final disposition of the grievance"). (See IMR Policy, QA Program).
6. There are some services that, if disputed, are not eligible for the IMR system. However, the DMHC is given the authority to require VCHCP to promptly offer the service, or reimburse the member for it, if it determines the service was a covered service and was medically necessary.
7. Members are also allowed to request voluntary mediation with VCHCP prior to exercising their right to submit a grievance to the DMHC. The DMHC still allows the member to submit a grievance to them after completion of mediation.

APPENDIX C

MEDICAL RECORD-KEEPING POLICIES

Purpose: The medical record communicates the patient's past medical treatment, past and current health status, and treatment plans for future health care. VCHCP demonstrates organizational accountability by establishing and promulgating medical records standards. VCHCP has medical record-keeping standards and ensures that practitioners in its network comply with the standard.

- To ensure that the treatment rendered to members and the response to treatment is consistently documented
- To provide a process of quality documentation
- To ensure that the information is current and detailed
- To reflect the safe and effective transfer of care between providers, and
- To maintain confidentiality of medical information
- To ensure standards for the availability of medical records are appropriate to the practice site
- To ensure that VCHCP has a process to assess and improve, as needed, the quality of medical record keeping

Scope

The standards are applied to the medical records of all VCHCP members.
Providers comply with all approved medical record-keeping policies and procedures.

These standards apply to:
a. All the services provided by the physician provider;
b. All ancillary services provided; and
c. All diagnostic tests ordered by the practitioner (such as reports for home health services, specialty physicians, hospital discharges, and physical therapy).

Confidentiality

Pursuant to federal requirements, all medical information is considered confidential. Refer to Quality Assurance policy on Confidentiality.

Policy

VCHCP requires medical records to be maintained in a manner that is current, detailed and organized and permits effective and confidential patient care and quality review.

Medical records will also be kept, at a minimum, in compliance with core elements to medical record documentation as defined by NCQA:

a. Maintenance of records
   1) Each member's medical record must be individually retrievable.
   2) The record is secured to maintain confidentiality and comply with regulation, including the Confidentiality of Medical Information Act & the Health Insurance Portability and Accountability Act (HIPAA).
   3) There is a section for patient identification, which includes demographic information such as address, phone # & emergency contacts.
   4) Every page in the record contains the member name & ID number.
   5) All entries contain author identification and date, and are legible to someone other than the writer.

b. Documentation
   1) Medication allergies are noted in a consistent, prominent place. Otherwise, no known allergies or history of adverse reactions are noted.
   2) Problem lists are used for members with significant illnesses and/or conditions which require ongoing monitoring.
   3) The record contains a list of current medications.
   4) The record contains a completed health history.
   5) The record contains past medical history which includes serious illnesses, accidents, operations & hospitalizations.
   6) The record demonstrates history & physical examination that is pertinent to presenting symptoms.
   7) The record demonstrates a working diagnosis that is consistent with findings.
   8) The record demonstrates treatment plans that are consistent with diagnosis.
   9) The record demonstrates no evidence of inappropriate risk by diagnostic or therapeutic procedures.
   10) The record contains consultation notes as applicable.
   11) The record demonstrates up-to-date preventive health and health maintenance screening.
   12) The record demonstrates up-to-date or appropriate history related to immunizations.
   13) The record includes health education. For Pediatrics, anticipatory guidance teaching is included.
   14) The record demonstrates appropriate follow-up when appointments are missed

15) The record demonstrates follow-up of unresolved problems on subsequent visits.
16) The record demonstrates notation regarding follow-up care, calls, or visits.

GUIDELINES: Medical Record Maintenance

Purpose

- To ensure the medical records are maintained according to regulatory and accreditation requirements,
- To maintain confidentiality of medical information, and
- To reflect the safe and effective transfer of care between providers.

Scope

The guidelines are applied to the medical records of all VCHCP members. All personnel of VCHCP and provider offices adhere to these guidelines.

Policy

1) The provider offices will comply with the VCHCP approved medical record guidelines and medical record-keeping standards.
2) Providers are required to maintain a centralized medical record for each member who receives care or service. The individual record includes appropriate documentation of the care and/or services provided.
3) Detailed mental health and substance abuse records may be filed separately in order to maintain confidentiality.
4) Providers are required to maintain policies and procedures, which address confidentiality. Each member care site will have a copy of the policy.
5) The member medical record is maintained in a current, detailed organized manner which reflects effective care of the member and facilitates quality review.
6) Medical record-keeping standards, medical record maintenance guidelines and quality improvement goals for the VCHCP are distributed to all network practice sites.
7) Practice site medical record protocols will specify appropriate charting and filing of information in the medical record.
8) Practice sites will have systems in place to ensure the availability of the medical records. The system must include a tracking mechanism that ensures the medical records of scheduled patients are available to practitioners at each encounter.

9) Practice sites will have systems for accurate and timely filing of medical record information. The system must include a mechanism to incorporate information between patient visits.

10) The medical record is a legal document and its contents shall be maintained in a confidential manner.

11) VCHCP has protocols that protect the information found in the medical record and clearly state how records are released. The protocols include:
    a) Patients are afforded the opportunity to approve or refuse the release of identifiable personal information, except when such release is required by law;
    b) Identifiable medical record information, when used for Utilization Management, Quality Assurance Management and case management activities is protected from disclosure;
    c) Identifiable claims information is protected from disclosure;
    d) The dissemination of confidential patient information by phone, written requests, etc.
    e) The requests of medical record information from regulatory agencies; and
    f) California regulations regarding medical record information. VCHCP's protocols include, but are not limited to:
        - The protection and security of confidential medical information to comply with the HIPAA legislation
        - The release of medical information to a county coroner in specified circumstances and disclosure to others in other circumstances
        - The release of certain confidential information to the non-covered custodial parent of a covered child
        - The disclosure of confidential information to independent review organizations and their reviewers without specific authorization by the patient.

12) The practice site will develop protocols to store, purge and archive medical record information. These protocols must also be in compliance with California regulatory requirements, which were amended in 2000, to state, in part, that every provider of health care who creates, maintains, preserves, stores, abandons, destroys, or disposes of medical records shall do so in a manner that preserves the confidentiality of the information.

13) The plan will conduct periodic audits on medical record protocol compliance and recommend actions for performance improvement.

14) Follow-up evaluations will be conducted for practice sites that have implemented improvement activities.

15) VCHCP member medical records are made available to authorized reviewers (e.g., regulatory and accreditation surveyors).

APPENDIX D

RULES GOVERNING COORDINATION OF BENEFITS (COB)

Coordination of Benefits (COB) is a provision used to address instances when a member is covered by more than one group health plan. In California, COB is regulated by state law.

Health plans in California which have COB provisions in their contracts with providers are required to make those provisions consistent with the standard provision set forth in subdivision (b) of Section 1300.67.13 of the California Code of Regulations (CCRs).

Additionally, the National Association of Insurance Commissioners (NAIC) has developed model COB regulations, which have been adopted by California.

When a VCHCP member is covered by more than one group health plan, payment of benefits may be coordinated between the VCHCP group health plan and the other carrier(s) group health plan.

Determining the order of payment

The California Code of Regulations provides the rules for determining the order of payment. The following information provides an overview of the general rules dictated by California law:

Note: for information on determining the order of payment when the patient is also covered by Medicare, refer to Medicare (Non-Duplication of Coverage).

In accordance with AB 2208 / AB 205, the domestic partner is treated like a spouse, and the children of the domestic partner are treated just like the children of a spouse for COB purposes - including the order of payment determination.

1) The member is a subscriber on one group health plan and a dependent of another group health plan:
   a. The group health plan that covers the person as an active employee, member, subscriber or retiree is primary.
   b. The group health plan that covers the person as a dependent is secondary.

2) The member is a child covered under more than one group health plan:
   a. When the parents are not divorced or separated, the group health plan of the parent whose date of birth (month and day) occurs earlier in the year is primary.
   b. When the parents are divorced and the specific terms of the court decree state that one of the parents is responsible for the health care expenses of the child, that group health plan is primary. The group health plan of the other natural parent is secondary.
   c. When the parents are not married, or are divorced or separated and there is no court order which would otherwise establish financial responsibility for the child, primary responsibility is determined in the following order:
      1. The group health plan of the custodial parent
      2. The group health plan of the spouse of the custodial parent
      3. The group health plan of the non custodial parent
      4. The group health plan of the spouse of the non custodial parent

   d. When the parents are divorced or separated, and there is a court decree that the parents share joint custody, without specifying which parent is responsible for the health care expenses of the child, the group health plan of the parent whose date of birth (month and day) occurs earlier in the year is primary.

3) The member has coverage provided via a retiree or laid-off employee group health plan and coverage provided under an active employee group health plan:
   a. The group health plan that covers the person, or the dependent of such person, as an active employee, is primary.
   b. The group health plan that covers the person, or the dependent of such person, as a aid-off or retired employee is secondary.

4) Exceptions
   a. Not all health care service plans and insurance plans coordinate benefits, for example:
      1. Individual and Family Plans (IFP);
      2. School or sports coverage;
      3. State, county and government plans, such as Healthy Kids and MRMIP;
      4. Tri-Care, which will always pay as secondary;
      5. Medi-Cal and Medicaid
      6. Medicare Supplement plans;
      7. Medicare (refer to Medicare (Non-Duplication of Coverage)

When VCHCP is the Primary Plan
When VCHCP is the primary carrier, VCHCP and /or the hospital will pay the claim according to the terms of the member's contract without considering the existence of any other group health plan.

The hospital may not bill or collect from the member any amounts in excess of the applicable copayments and deductibles. The hospital may also bill and collect from any secondary carrier, according to the secondary carrier's payment rules.

When VCHCP is the Secondary Plan
When VCHCP is the secondary carrier our payment is limited to the VCHCP benefits, less the primary carrier's payment. VCHCP does not make payment if the primary carrier pays up to or more than the VCHCP allowance for the billed charges. Although the hospital may recover copayments and/or deductibles from the member, the total amount collected may never exceed the VCHCP allowance for the billed services.

If VCHCP is the secondary plan, and the hospital provides a service that would have otherwise been the primary group health plan's liability, the hospital may collect the reasonable cash value of such services from the primary group health plan. If VCHCP is a member's secondary group health plan, the capitated hospital will waive collection of the VCHCP member copayment.

When a disagreement exists as to which group health plan is secondary, or the primary group health plan has not paid within a reasonable period of time, VCHCP or the capitated will provide benefits as if it were the primary group health plan, provided the member:

1. assigns to VCHCP the right to receive benefits from the other group health plan;
2. agrees to cooperate with VCHCP in obtaining payment from the other group health plan; and
3. allows VCHCP to verify benefits have not been provided by the other group health plan.

VCHCP and/or the capitated hospital will work directly with the other group health plan to recover the reasonable cost of benefits provided to the member.

Healthy Families Program
The Healthy Families Program is always considered secondary to other health coverage with the exception of MediCal. Under the rules of the Healthy Families Program, the benefits of the plan will not duplicate coverage the member may have under any other program or plan.

Note: Conditions eligible for coverage through California Children's Services (CCS) are not eligible for coverage through the Healthy Families Program.

References
Additional information regarding COB is available through the following references:

- California Code of Regulations, Title 28, Section 1300.67.13
- The Member's Evidence of Coverage

APPENDIX E

CHECK LIST FOR A COMPLETE MEDICAL RECORD

Medical Records Requirements

Consistent and complete documentation in the medical record is an essential component of quality patient care. Personal physicians are required to maintain a medical record for each member. The record should be current and organized in a manner that permits effective and confidential patient care and quality review. Please refer to the medical records review section in this manual for additional information.

The form below is provided to help you determine the key elements required for a complete medical record.

	Yes	No	N/A
1. Do all pages contain patient ID?			
2. Is there a completed problem list?			
3. Are allergies and adverse reactions to medications prominently displayed?			
4. Is there an appropriate past medical history in the record?			
5. Are working diagnoses consistent with findings?			
6. Are plans of action/treatment consistent with diagnoses?			
7. Are the initial and refill prescriptions noted?			
8. Is there evidence of continuity and coordination of care between primary and specialty physicians?			
9. Does the care appear to be medically appropriate?			
10. Is there evidence of a discussion of Advanced Directives for adults over age 18?			

APPENDIX F

GLOSSARY

Advanced Directives
Documents signed by a member that explain the member's wishes concerning a given course of medical care should a situation arise where he/she is unable to make these wishes known.

Authorization
The procedure for obtaining VCHCP's prior approval for all services, except PCP and emergency or urgent services, provided to members under the terms of their health services contract.

Benefits
Those health care services, for which a member is entitled, pursuant to the terms of his/her health services contract.

Capitation
A prepaid monthly fee paid to the PCP for each VCHCP member in exchange for the provision of comprehensive health care services.

Complete Claim
VCHCP will adjudicate complete claims. A complete claim is a claim, or portion of a claim, including attachments and supplemental information or documentation, that provides reasonably relevant information or information necessary to determine payer liability and that may vary with the type of service or provider. Reasonably relevant information means the minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator to determine the nature, cost, if applicable, and extent of the plan's liability, if any, and to comply with any governmental information requirements. Information necessary to determine payer liability means the minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator to determine the nature, cost, if applicable, and extent of the plan's liability, if any, and to comply with any governmental information requirements. In addition, the plan may require additional information from a provider where the plan has reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices.

Coordination of Benefits (COB)
When a patient is covered by two or more group health plans, coordination of benefits divides the responsibility of payment between the health plans so that the combined coverage may

pay up to 100 percent of hospital and professional services within the limits of all contracts.

Copayment
Fees paid by the member to the healthcare provider at the time of service. Copayment pertains only to covered services, as specified in the member's Evidence of Coverage.

Covered Services
Those services provided to a member pursuant to the terms of a group or individual health services contract and noted in the member's Evidence of Coverage.

Dependent (Commercial only)
A subscriber's spouse who:

- is not covered for benefits as a subscriber
- must reside with the subscriber, except as otherwise required by law or court order.
- has been enrolled and accepted by the Plan as a dependent and has maintained membership in accordance with the health services contract.

A subscriber's Domestic Partner, who:

- is not covered for benefits as a subscriber
- .

A dependent is also a subscriber's unmarried child (including stepchild, legally adopted child, or child of domestic partner) who:

- is primarily dependent upon the subscriber for support and maintenance
- under the limiting age of 26
- is not covered for benefits as a subscriber
- has been enrolled and accepted by the Plan as a dependent and has maintained membership in accordance with the health services contract.

Note: If a court has issued a Qualified Medical Child Support Order, VCHCP will provide coverage for the child in accordance with that order, whether or not the child meets the above requirements.

Domestic Partner
An individual who is personally related to the subscriber by a domestic partnership that meets the following requirements:

- The domestic partnership is officially registered with the State of California or with any other California county or municipality domestic partner registry listed at the San Francisco Human Right Commission Internet site www.ci.sf.ca.us .
-

Durable Medical Equipment-DME (also known as Home Medical Equipment- HME)
Equipment, as defined by Medicare coverage guidelines, that can withstand repeated use, is primarily and usually used to serve a medical

purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home.

Durable Power of Attorney
A legal document that enables an individual to designate another person, called the attorney-in-fact, to act on his/her behalf, even in the event the individual becomes disabled or incapacitated.

Eligibility Report
A report of members determined by VCHCP to be eligible for benefits.

Emergency
An emergency is defined as a medical condition (including active labor or a psychiatric medical condition) manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would believe without immediate medical attention could result in:

- Placing a member's health, or that of the member's unborn child, in jeopardy;
- Seriously impairing bodily functions; or
- Causing serious dysfunction of any bodily organ or part.

Employer Group
The organization, firm, or other entity contracting with VCHCP to arrange health care services for its employees and their dependents.

Evidence of Coverage and Disclosure
The document which explains the services and benefits covered by VCHCP and defines the rights and responsibilities of the member and VCHCP.

Exclusions
An item or service that is not covered under VCHCP as defined in the Evidence of Coverage and Disclosure.

Expedited Grievance
A request for a 72-hour grievance consideration of a prior authorization request denial in which the health plan determines a member's health or ability to function could be seriously harmed by waiting for a standard grievance decision. An expedited grievance may be requested by a member, member representative, or physician on behalf of the member.

Expedited Initial Determination
Prior authorization request which have been requested by the member or requesting provider to be reviewed within a 72-hour time frame, or when it is determined by the health plan or the requesting provider that the member's health or ability to function could be seriously harmed by waiting for a standard review determination.

Expedited Review or Decision
The Knox Keene Act requires and provides for an expedited review (initial determination) and grievance process. When a member believes that his/her health and ability to function could be seriously harmed by waiting the thirty days (30) for a standard

grievance, he/she may request an expedited review (initial determination) or grievance. DMHC standards and VCHCP require that this request be processed within seventy-two (72) hours. This request may be filed by the member, his/her representative or his/her physician on behalf of the member.

External Review

An option provided to commercial members for consideration of

- A medical necessity decision following a Second Level or Final Level Grievance; or
- A grievance in which care for a member with a terminal illness has been denied on the grounds that the treatment is experimental; where the case is sent to an independent, external review organization for an opinion, which is binding on VCHCP.

Fee for Service (FSS)

A payment system by which doctors, hospitals, and other providers are reimbursed for each service performed. VCHCP (FFS) contracts are typically based on the Medicare RBRVS reimbursement system.

Formulary (Preferred Drug List)

A continually updated list of prescription medications that VCHCP covers. The list represents the current clinical judgment of the members of the VCHCP Pharmacy and Therapeutics Committee as well as the physicians and pharmacists of the pharmacy benefit management (PBM) company used by the plan.
The formulary contains both brand name and generic drugs, all of which have FDA (Food and Drug Administration) approval

Grievance

Any concern related to quality of care, quality of service, access, waiting time, etc.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 Public Law 104-191 (HIPPA) was passed by Congress to reform the insurance market and simplify health care administrative process. Regulations govern the transmission, maintenance, security and privacy of electronic health information transmitted by health care providers, payors and others.

Home Health Care

Medically necessary healthcare services provided by a home health agency at the patient's home, as prescribed by the PCP.

Initial Decision/ Initial Determination

When VCHCP decides whether a service, claim, or benefit is authorized or denied.

Limitations

Refers to services that are covered by VCHCP but only under certain conditions.

Medically Necessary

Benefits are provided for covered services that are medically necessary. Medically necessary services include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness or injury and which, as determined by VCHCP, are:

- Consistent with VCHCP medical policy.
- Consistent with the symptoms and diagnosis.
- Not furnished primarily for the convenience of the patient, the attending physician or other provider.
- Furnished at the most appropriate level that can be provided safely and effectively to the patient. The fact that a provider prescribes, orders, recommends or approves health services does not in itself make them medically necessary.

Non-Covered Services

Health care services which are not benefits under the subscriber's Evidence of Coverage/Disclosure Form.

Peer Review

A physician review for the purposes of determining the existence of an actual or potential quality of care issue. This review process includes a review of the clinical and administrative information available. It is the evaluation or review of the performance of colleagues by professionals with similar types and degrees of expertise.

Primary Care Physician (PCP)

A general practitioner, board-certified (if not board certified, must at least have completed a two-year residency program) or board-eligible family practitioner, internist, obstetrician/gynecologist or pediatrician who has contracted with VCHCP to provide benefits to members and to refer, authorize, supervise, and coordinate the provision of all benefits to members in accordance with their health services contract and the Plan service delivery guidelines.

Referral

The process by which a member obtains authorization for covered services rendered by providers other than the member's Primary Care Physician.

Service Area

That geographic area in which VCHCP is licensed to provide services to members. Ventura County is the service area for VCHCP.

Skilled Nursing Facility (SNF)

A facility certified to provide skilled care, rehabilitation, and other related health services. The term "skilled nursing facility" or "SNF" does not include convalescent nursing homes, or facilities which primarily furnish custodial care.

Subscriber
A group employee or individual who satisfies the eligibility requirements of the health services contract, who is enrolled in and accepted by the Plan.

Urgent Service
Those services (other than Emergency Services) which are medically necessary to prevent serious deterioration of a Member's health, alleviate severe pain, or treat an unforeseen illness, injury or medical condition with respect to which treatment cannot reasonably be delayed until the Member returns to the Plan's service area.