2022

PROVIDER SERVICES GUIDE

This is only a summary. Please consult the Provider Operations Manual or call the Plan directly for more detailed information at Member & Provider Services (805) 981-5050

Contact Information

REGULAR BUSINESS HOURS ARE:

Monday - Friday, 8:30 a.m. to 4:30 p.m.

- vchealthcareplan.org
- Phone: (805) 981-5050
- Toll-free: (800) 600-8247
- FAX: (805) 981-5051
- Language Line Services:
  Phone: (805) 981-5050
  Toll-free: (800) 600-8247
- TDD to Voice: (800) 735-2929
- Voice to TDD: (800) 735-2922
- Pharmacy Help: (800) 811-0293 or express-scripts.com
- Behavioral Health/Life Strategies:
  (24-hour assistance)
  (800) 851-7407 or
  liveandworkwell.com
- Nurse Advice Line: (800) 334-9023
- Teladoc: (800) 835-2362

Provider Services Email:

VCHCP.ProviderServices@ventura.org

Email is responded to Monday - Friday, 8:30 a.m. - 4:30 p.m.

- The Ventura County Health Care Plan (VCHCP) has a **Dedicated Provider Services/Provider Relations Team** designed to support our Provider community. If you are a provider or provider office that requires any assistance, you may contact VCHCP at (805) 981-5050 or email us at the email address listed above.

VCHCP 24-Hour Administrator Access for emergency provider at:

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

VCHCP Utilization Management Staff

Regular Business Hours are:

Monday - Friday, 8:30 a.m. to 4:30 p.m.

- Phone: (805) 981-5060

Timely Access Requirements

STANDARDS INCLUDE:

VCHCP adheres to patient care access and availability standards as required by the Department of Managed Health Care (DMHC). The DMHC implemented these standards to ensure that members can get an appointment for care on a timely basis, reach a provider over the phone and access interpreter services, if needed. Contracted providers are expected to comply with appointment, telephone access, practitioner availability and linguistic service standards.

TYPE OF CARE	WAIT TIME OR AVAILABILITY
Emergency Services	Immediately, 24 hours/day, 7 days/week
Urgent Need—No Prior Authorization Required	Within 48 hours
Urgent Need—Requires Prior Authorization	Within 96 hours
Primary Care	Within 10 business days
Specialty Care	Within 15 business days
Ancillary services for diagnosis or treatment	Within 15 business days
Mental Health	Within 10 business days
Waiting time in provider office (to speak with triage nurse)	30 minutes
Ensure wait time for enrollees to speak with qualified representative during business hours	Not to exceed 10 minutes

TREATMENT AUTHORIZATION REQUESTS (TAR) PROCESS

- When VCHCP clinical staff identifies that additional information is needed to complete a TAR determination, a pend letter will be sent to the requesting provider and to the member for whom the authorization is being requested. The pend letter will indicate that…
  a) The TAR has been pended
  b) What information is missing
  c) Will provide for up to 45 calendar days (for routine TAR requests) for the requested additional information to be submitted to VCHCP.

Per DMHC requirements, a TAR can only be pended once, additional requests for information will not be sent and VCHCP will not send a reminder.

- When the information is submitted within 45 days, a final determination will be made within 5 business days for a routine TAR, and notification will be sent to the requesting provider and to the member within 24-hours of the decision*.
- If the requested information is not submitted within 45 days, a final determination will be made based on the initial information submitted and may be denied by the VCHCP Medical Director.
- To assist VCHCP staff with the efficient review of these requests, and to avoid delays in the review process, the following is appreciated at the time the TAR is initially submitted:
  a) Please provide specific clinical information to support the TAR. For example, the History and Physical (H&P), key lab or test results, and plan of care from the most recent office visit (this is usually sufficient) if the office visit specifically relates to the TAR.
  b) For providers using CERNER, please provide the exact place in CERNER where the specific clinical information can be located to support the TAR. "See Notes in CERNER" does not adequately describe what clinical information supports the TAR, and should be reviewed
  c) If written notes are submitted, please be sure they are legible.

If you have any questions, please contact VCHCP Utilization Management Department at: (805) 981-5060.

*These timeframes will apply in most situations. There may be some variance with urgent and retrospective TAR requests. Please see the VCHCP TAR Form for the timeline descriptions. Link: vchealthcareplan.org/providers/docs/preAuthorizationTreatmentAuthorizationForm.pdf

Prescription Drug Prior Authorization or Step Therapy Exception Request Form

Effective December 2016, the Department of Managed Health Care (DMHC) updated their mandated Prescription Drug Prior Authorization Request Form to include a box for Step Therapy Exception Request. Additionally, DMHC added a box for Exigent Circumstances. "Exigent circumstances" exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug. The Plan has 24-hours to complete the review of exigent circumstances from receipt of request.

This Prescription Drug Prior Authorization and Step Therapy Exception Request form as well as the updated Prescription Drug Prior Authorization and Step Therapy Exception Request Form Legislation are posted on our website: vchealthcareplan.org/providers/hsApprovalProcess.aspx. Please complete this form when sending prior authorization requests for prescription/pharmacy medication requests to VCHCP. Since this is a DMHC required form, the Plan will return prior authorization requests for prescription/pharmacy medication requests that are not written in this form.

If you have any questions, please feel free to call our Medical Management Department at…
(805) 981-5060 Monday – Friday from 8:30 am to 4:30 p.m.

SPECIALTY *Medication Request* & ACCREDO

Accredo manages the specialty medication program for VCHCP. Accredo is a sub-division of Express Scripts, the plan's pharmacy benefit manager. If you are prescribing a specialty medication for a VCHCP member, please complete a Pharmacy Request Form and submit it to the Health Plan for a decision.

For the complete Specialty Medication Program Description and list of included Specialty Drugs, visit vchealthcareplan.org/providers/docs/drugListSpecialty.pdf

If you have questions, please contact our UM Department at (805) 981-5060.

Direct Specialty Referrals

A "Direct Specialty Referral" is a referral that the Primary Care Physician (PCP) can give to members so that members can be seen by a specialist physician or receive certain specialized services. Direct Specialty Referrals do not need to be pre-authorized by the Plan. All VCHCP contracted specialists can be directly referred by the PCPs using the direct referral form [EXCLUDING TERTIARY REFERRALS, (e.g. UCLA AND CHLA), PERINATOLOGY and NON VCMC PAIN MANAGEMENT SPECIALISTS]. Referrals to Physical Therapy, Occupational Therapy, and Nutritional Counseling also use this form.

Note that this direct specialty referral does not apply to any tertiary care or non-contracted provider referrals. All tertiary care referrals and referrals to non-contracted providers continue to require approval by the Health Plan through the treatment authorization request (TAR) procedure.

The Direct Referral Policy can also be accessed at: vchealthcareplan.org/providers/providerIndex.aspx. To request a printed copy of the policy mailed to you, please call Member Services at (805) 981-5050 or (800) 600-8247.

Electronic Claims Submission

PROVIDERS: You can transmit your CMS-1500 and UB-04 claims electronically to Ventura County Health Care Plan through Office Ally!

Office Ally offers the following services and benefits to Providers: No monthly fees, use your existing Practice Management Software, free set-up and training, 24/7 Customer Support, and other clearinghouse services.

Just think….no need for the "paper claim". Within 24-hours, your File Summary is ready. This report will list the status of all your claims received by Office Ally. This acts as your receipt that your claims have been entered into their system.

The File Summary reports all claims you've sent and are processed correctly; as well as keeping track of rejected claims that you may need to resubmit for processing.

Ready to make a change for the better???
Contact Office Ally at: (360) 975-7000 or Officeally.com

Paper Submission

In order for the Plan to process paper claims as quickly, accurately, and efficiently as possible, 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). For hospital and other facility providers the UB-04 (CMS 1450) is used. The Official UB-04 Data Specification Manual is the official source of UB-04 billing information as adopted by the National Uniform Billing Committee (NUBC). Please send claims to:

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

Please see your Provider Operations Manual for more information about billing and payment.

You can also reach out to us at VCHCP.ProviderServices@ventura.org for a copy of the Provider Welcome Packet.