VENTURA COUNTY
HEALTH CARE PLAN

Ventura County Health Care Plan

Sponsored by the

County of Ventura

Provider Operations Manual

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Section 1 - Introduction

About the Ventura County Health Care Plan (VCHCP)

Welcome to the VCHCP.

Thank you for your interest and participation in the Ventura County Health Care Plan (VCHCP).

The Ventura County Health Care Plan was formed in November 1993 under a California state law that 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.

At present, VCHCP has one line of business and benefit plan namely, commercial.

Services are provided to members by a combined network of providers consisting of the Ventura County Medical Center (VCMC) and ambulatory care system, and contracted community hospitals 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.

Purpose of the Operations Manual

This Provider Manual is intended as a communication tool and reference guide for *Ventura County Health Care Plan* (VCHCP) providers and their office staff. It contains basic information about how to work with VCHCP, how to refer members to specific services, and explains our plan policies and billing procedures to help 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).

The information in this manual 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.

Operations Manual Orders and Updates

The Physician Operations Manual will be updated and distributed to all participating practitioners annually via the individual provider's preferred method of contact (mail, fax or e-mail). Any updates throughout the year will be distributed through a provider newsletter and/or through the website at www.vchealthcareplan.org. The Plan uses the individual provider's preferred method of contact (mail, fax, or e-mail) to notify practitioners that new or updated information is available. Printed materials are available to providers upon request.

In the event of a conflict or inconsistency between federal and state regulatory requirements and this manual, the provisions of the regulatory requirements prevail.

Any additional information or details about any of VCHCP policies and procedures can be obtained by calling Member/Provider Services at (805) 981-5050 or (800) 600-8247, via email at VCHCP.ProviderServices@Ventura.org or by accessing the provider website at www.vchealthcareplan.org.

For your convenience, we have made this manual available to you online at Provider Connection, VCHCP's provider website. To access Provider Connection, go to www.vchealthcareplan.org. More detailed information about Provider Connection can be found in the following section. If you wish to order additional printed copies of this manual, please contact Member/Provider Services at (805) 981-5050 or toll free at (800) 600-8247.

Provider Connection

"Provider Connection" is your online resource for quick and convenient information on our medical policies and procedures, member benefits and eligibility, and more. It gives you access at any time to:

- View provider network updates
- Get the most current information on new technology and procedures approved for coverage.
- 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
- Review our Clinical Practice Guidelines (including Diabetes, Asthma, and Preventive Health Guidelines); located in the Medical Policies section, under Quality Assurance.
- Provider Dispute Resolution Notice and Request Form
- Group Practice or Individual Provider Update Process and Request Form or Report Directory Inaccuracies
- Provider Services Guide

- An electronic copy of this Provider Operations Manual (in PDF format)

To have a copy of any of the above-mentioned guidelines or policies mailed to you, please contact Member/Provider Services at (805) 981-5050 or (800) 600-8247 or VCHCP.ProviderServices@ventura.org.

How to Access Provider Connection

To access Provider Connection, go to **www.vchealthcareplan.org** and click on "Provider Connection" on the left-hand menu.

Dedicated Provider Services/Relations Team

We have a dedicated Provider Services/Relations Team that is designed to support our provider community. Please reach out to us at the phone number or email address listed below if you need assistance with a general question or the following:

- Updating Office Information
  - Adding / Terminating a provider or location
  - Open / Close to new members
  - Contact information
  - Address change
  - Tax ID / NPI change
- Provider Disputes
- Provider Materials
- Report Directory Inaccuracies

Provider Services: (805) 981-5050 or Email at: VCHCP.ProviderServices@Ventura.org

Key Health Plan Contacts

General Plan Address:

Ventura County Health Care Plan
2220 E. Gonzales Road, Suite 210-B
Oxnard, CA 93036
Website: www.vchealthcareplan.org

Plan Administration:

Dee Pupa
(805) 981-5006*

Medical Director:

Howard Taekman, M.D.
(805) 981-5024*

Director of Health Services:

Faustine Dela Cruz
(805) 981-5058*

Utilization Management:

Faustine Dela Cruz
(805) 981-5058*

Director of Member & Provider Services:

Christina Woods
(805) 981-5086

***Collect calls will be accepted**

Member Services:

Erick Hernandez
(805) 981-5121

Provider Services/Relations:

Noemi Solomon
(805) 981-5137

General Phone Number

(805) 981-5050 or (800) 600-8247
For General Inquiries and access to UM staff during normal business hours.

Claims Processing:

Michelle Myricks, Supervisor
(805) 981-5037*

'After-Hours' Contact Information:

24-hour Administrator access is available through Central Communications by calling the Plan's main telephone number, (805) 981-5050, or (800) 600-8247 and selecting the appropriate number for on-call assistance.

VCHCP Member and Provider Services

Representatives are available to answer questions from Members, Practitioners and Providers concerning:

- Member eligibility
- Covered services/benefits
- Utilization Management Information/Issues
- Deductibles and copayments
- Claims status

Representatives can be reached during the hours of 8:30 a.m. to 4:30 p.m. Monday through Friday by calling (805) 981-5050 or toll free at (800) 600-8247.

Members, Practitioners and Providers can also contact the Plan's Member and Provider Services Staff via email at:

- For Members – vchcp.memberservices@ventura.org
- For Providers – vchcp.providerservices@ventura.org

Emails are monitored and answered between the hours of 8:30 am and 4:30 pm, Monday through Friday, except for holidays.

TDD to Voice (800) 735-2929; Voice to TDD (800) 735-2922 English, or (800) 855-3000 to communicate in Spanish.

For assistance with benefits, eligibility, claims, or utilization management information, members and practitioners may also access the website at: www.vchealthcareplan.org

Behavioral/Mental Health Services

Providers or members wishing to find out more about behavioral or mental health services can call the Plan's behavioral health program administrator, OptumHealth Behavioral Solutions (AKA Life Strategies), at (800) 851-7407 or online at https://www.liveandworkwell.com. Providers can contact Optum's Physician Consultation Line at (800) 292-2922, Monday through Friday, 8:00 am to 5:00 pm PST for an appointment with an Optum Health Behavioral Solutions Medical Director or go to the Provider Express website at https://www.providerexpress.com/.

Following is a reference card for facilitating access to behavioral health services for VCHCP members. It contains a 24-hour helpline for VCHCP providers and members to utilize, and Optum's Intake and Care Management phone number.

VCHCP Member Behavioral Health and Substance Abuse Resources

Substance Use Disorder Helpline: 1-855-780-5955

A 24/7 helpline for VCHCP Providers and Patients to:

- Identify local MAT and behavioral health treatment providers and provide targeted referrals for evidence-based care
- Educate members/families about substance use
- Assist in finding community support services
- Assign a care advocate to provide ongoing support for up to 6 months, when appropriate

Member Website and Provider Directory

LiveandWorkWell.com

Optum Intake and Care Management for Intake and Referrals

(800) 851-7407

Optum covers all Substance-Use-Disorder services identified in the American Society of Addiction Medicine (ASAM) criteria, and as of January 1, 2021, this includes ASAM levels 3.1 and 3.2 WM services.

California "Department of Managed Health Care" (DMHC)

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

Utilizing 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 VCHCP, or a grievance that has remained unresolved for more than 30 days, the member may contact 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) 466-2219** and a TDD line **(877) 688-9891** for the hearing and speech impaired. DMHC's internet website, **www.dmhc.ca.gov**, has complaint forms, IMR application forms and instructions online to assist plan members.

Fraud Prevention

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

Healthcare 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 healthcare program. Healthcare 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.

Healthcare 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. Healthcare 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 website for guidance on billing procedures and prevention of inappropriate practices.

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:

1. Conduct activities in accordance with all applicable laws and regulations,
2. Avoid allowing any outside financial interests to influence decisions or actions taken on behalf of VCHCP,
3. Protect confidential and proprietary information,
4. Avoid purchasing goods or services without VCHCP approval from any business in which a team member or close relative has a substantial interest,
5. Record and report all business information fully, accurately and honestly,
6. Avoid offering or accepting entertainment, which is primarily intended to gain favor or influence,
7. 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,
8. Prevent unauthorized use of VCHCP or VCMC Information systems, and
9. 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) 981-5006**.

SECTION 2 – MEMBER SERVICES

Member Rights & Responsibilities

Ventura County Health Care Plan is committed to maintaining a mutually respectful relationship with its members that promotes effective health care. Standards for Members Rights and Responsibilities are as follows:

- Members have a right to receive information about VCHCP, its services, its Practitioners and Providers, and Members' rights and responsibilities.
- Members have a right to be treated with respect and recognition of their dignity and right to privacy.
- Members have a right to participate with Practitioners in decision making regarding their health care.
- Members have a right to a candid discussion of treatment alternatives with their Practitioner regardless of the cost or benefit coverage of the Ventura County Health Care Plan.
- Members have a right to voice complaints or appeals about VCHCP or the care provided.
- Members have a right to make recommendations regarding VCHCP's member rights and responsibilities policy.
- Members have a responsibility to provide, to the extent possible, information that VCHCP and its Practitioners and Providers need in order to care for them.
- Members have a responsibility to follow the plans and instructions for care that they have agreed upon with their providers.
- Members have a responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

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, they may contact Member Services (805) 981-5050 or (800) 600-8247 and a representative can assist them.

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 B 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.

VCHCP requires providers to make available, upon request, a grievance/complaint form to the member, and should maintain a supply of such forms in their offices. This form can be downloaded from our website at:

http://www.vchealthcareplan.org/members/docs/GrievanceFormEnglish.pdf

If you would like a copy of this form mailed to your office, please contact Member/Provider Services at (805) 981-5050 or toll free at (800) 600-8247. Directing a member back to the Plan or to the website in lieu of providing the document to them, does **not** comply with DMHC, Health and Safety Code 1300.68 (b)(7).

SECTION 3 – PHYSICIAN/PROVIDER RIGHTS AND RESPONSIBILITIES

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 subscriber 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, gender, 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-10 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 cooperate with the VCHCP's QI activities to improve the quality of care and services and member experience. Cooperation includes collection and evaluation of data and participation in the organization's QI programs. Providers allow VCHCP to use their performance data for quality improvement activities.
- Providers agree to deliver services within a reasonable time period, as defined in the access-to-care guidelines contained in **Appendix A**.

Termination of Patient/Physician Relationship

The following is taken from the Medical Board of California's rule regarding termination of patient/physician relationship. Please refer to MBC.gov for information.

Although a physician is allowed to sever or terminate the patient/physician relationship, in order to avoid allegations of patient abandonment (unprofessional conduct), a physician should notify patients of the following in writing when the physician wishes to discontinue care:

- The last day the physician will be available to render medical care, assuring the patient has been provided at least 15 days of emergency treatment and prescriptions before discontinuing the physician's availability.
- Alternative sources of medical care, i.e., refer patient to other physicians, by name, or to the local medical society's referral service.
- The information necessary to obtain the medical records compiled during the patient's care (whom to contact, how and where).

VCHCP request that providers notify the Plan anytime there is a termination of patient/physician relationship and provide a copy of the letter that was sent to the member.

Patient Advocacy

The patient's physician is responsible for being an advocate on behalf of VCHCP patients. Physicians can do this in any 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

Providers shall comply with VCHCP's Language Assistance Program (LAP) standards and methods developed pursuant to the Knox-Keene Act and Regulations. Providers 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, providers 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. Contracted providers receive monthly enrollment reports from the Plan that 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 fluent in medical 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 located at

http://www.vchealthcareplan.org/providers/docs/LAP_Policies_and_Procedures.pdf

To access the AT&T Language Line, call 1-800-774-4344, 24 hours per day, 7 days a week. The VCHCP Client Number is 501156.

Provider Credentialing

OVERVIEW

To help ensure a quality health care delivery system, VCHCP requires new providers, including physicians and non-physician providers, to be credentialed as part of the

contracting process with VCHCP. VCHCP also requires its providers to be re-credentialed every three (3) years.

VCHCP has established the following criteria for practitioner participation in the VCHCP network. If the practitioner does not meet one or more of the following criteria, the Credentialing Committee (CC) considers the practitioner's history on an individual basis.

- A current, valid, unencumbered, unrestricted, and non-probationary state license with no unresolved public records in a five year look back period.
- Current, valid, and unrestricted DEA certificate for prescribing controlled substances, if applicable to his/her practice in which he/she will treat the Plan's members.
- Verification of clinical privileges in good standing, including status and type, from the applicant's primary admitting facility. If the applicant does not admit patients to the hospital, the verification form, indicating that the applicant has arrangements for VCHCP members to receive needed hospital care, is completed.
- Must not be currently debarred or excluded from participation in Medicare or Medicaid programs.
- Current malpractice insurance coverage consistent with limits established by VCHCP (Limits of Liability at a minimum $1 million to $3 million aggregate).
- Application and supporting documentation must not contain omissions or falsifications, (including any additional information requested by VCHCP). Attestation as to the completeness and accuracy of the application must be signed.
- Education, training, and certification must meet criteria for the specialty in which the applicant will treat the VCHCP members. Board Certification or Board eligibility is required for new MDs and DOs applying after October 15, 2012. If Board Eligible, applicant must become Board Certified after completion of training, at the first opportunity to take certification exam based on time frame specific to each specialty board. VCHCP may consider exceptions based on network needs or other extenuating circumstances on a case-by-case basis.
- Site visit and medical record review results, if applicable, must meet VCHCP standards.
- Complaints from members and/or other providers must be at levels deemed acceptable to VCHCP.
- Explanations for gaps in work history must be documented and deemed acceptable to VCHCP.
- History of professional liability suits, arbitrations or settlements must be within established VCHCP standards, or in the presence of suits exceeding such standards are reviewed by the CC on an individual basis.
- No physical or mental impairment, (including chemical dependency and substance abuse), that would affect the practitioner's ability to practice within the scope of his or her license or pose a risk or imminent harm to members. In the presence of a history of physical or mental impairment, the nature of the

impairment and other information obtained during the credentialing or recredentialing process are reviewed by the CC on an individual basis.

- No history of disciplinary actions, sanctions, or revocations of privileges taken by hospitals and other healthcare facilities or entities, HMOs, PPOs, PHOs, etc. or, in the presence of such actions or sanctions, the CC's determination is based upon the nature of the disciplinary action or sanction and other information obtained during the credentialing or recredentialing process.
- No open indictments, convictions, or pleadings of guilty or no contest to, a felony, and no open indictments or convictions to any offense involving moral turpitude, fraud, or any other similar offense.
- No other significant information, such as information related to improper or unethical professional conduct, including, but not limited to boundary issues or sexual impropriety or illegal drug use, which might indicate a reasonable suspicion of future substandard professional conduct and/or competence. If present, the information is reviewed by the CC on an individual basis.
- A Language Assistance attestation form must be filed and maintained by the VCHCP attesting to the language(s) spoken by providers and/or office staff.

Practitioner Rights During the Credentialing Process

Right to Review Information

VCHCP staff provides practitioners the opportunity to review information used in the credentialing process, upon request. Practitioners may review the information at the VCHCP offices or receive copies of the information in a secure and confidential manner.

The evaluation may include information obtained from outside primary sources (such as malpractice insurance carriers or state licensing boards). The review does not include NPDB or HIPDB reports, references or recommendations, or other information that is peer review protected. VCHCP is not required to reveal the source of information if the information is not obtained to meet credentialing verification requirements or if disclosure is prohibited by law.

Right to Correct Erroneous Information

Practitioners have the right to correct erroneous information collected during the credentialing process. VCHCP staff notifies the practitioner if the credentialing information obtained from other sources varies substantially from that supplied by the practitioner, including but not limited to actions on a license, malpractice claims history, or board certification.

The practitioner is notified by phone call, fax, or certified letter as soon as possible after receipt of the conflicting information.

VCHCP advises the practitioner of the nature of the discrepancy and asks the practitioner to submit a response to clarify or correct the information. The response must be submitted in writing (via mail, email, or fax) to the Credentialing Department, with supporting documentation, if available, within ten (10) working days of notification. The practitioner's response is recorded and placed in the credentialing file for review by the CC Chair and the CC.

Right to Be Informed of Application Status

VCHCP staff informs practitioners of the status of their credentialing or recredentialing applications, upon request. In response to such a request, one of the following status statements is provided by telephone, email, or fax:

- "Application required from practitioner"
- "Application returned to the practitioner to supply complete information"
- "Awaiting information from the practitioner"
- "Processing application"
- "Being reviewed by the Medical Director"
- "Application scheduled to be presented to the Credentialing Committee"
- "Application approved"
- "Committee decision pending additional information from practitioner"
- "Application disapproved"
- "Application withdrawn"

Request can be emailed to VCHCP.ProviderServices@ventura.org or by mail or Fax at:

VCHCP Credentialing Department

2220 E Gonzales Rd #210B

Oxnard, Ca 93036

805-981-5051(F)

Terminations

When issues related to a practitioner's professional conduct and/or competence are identified, the CC Chair evaluates the issue and refers the matter to the CC for review. The CC renders a decision of suspension or termination for cause during a re-credentialing review or during an off-cycle review.

The Peer Review subcommittee of the QAC may recommend to the Medical Director and the CC that the privileges of a practitioner be altered including termination. This could include the recommendation for immediate suspension or termination.

The practitioner is notified in writing of the CC's decision of limitation of privileges, suspension, or termination for cause (professional review action) and advises the practitioner of the reasons for the action, the right to appeal the determination and a summary of the appeal rights and process. The notification is signed by the CC Chair. If the practitioner exercises his/her right to appeal, the practitioner is provided an appeal in accordance with procedure defined in the "Practitioner Appeal Process" section below.

If the practitioner does not invoke the right to an appeal or the appeals process, the CC's decision to suspend or terminate the practitioner is upheld and the Member Services Department is notified of the effective date of the termination.

Immediate Termination

In circumstances that may require immediate termination in an expedited timeframe, the CC Chair acts on behalf of the CC and investigates circumstances and makes a determination. If appropriate, the CC Chair implements the process for immediate termination if a practitioner's continued participation in VCHCP network poses potential risk to the health or welfare of one or more of VCHCP's members or may potentially result in imminent danger to the health or welfare of one or more of the VCHCP members due to specific issues of professional conduct and competence. The CC Chair may consult with legal counsel regarding the circumstances of the need for immediate termination.

The CC Chair issues written notice of an adverse decision on behalf of the CC to the affected practitioner and provides the practitioner an appeal in accordance with procedure defined in the "Practitioner Appeal Process" section below. The CC Chair reports and reviews the immediate termination action at the next scheduled meeting of the CC.

The affected practitioner has the right to appeal, but participation may not be reinstated during the appeals process. If a decision to terminate a practitioner immediately is overturned on review or appeal, the practitioner is reinstated and he/she does not lose any of the protections to which the practitioner had been entitled before the immediate termination.

Practitioner Appeal Process

Written Notification of Proposed Action

The practitioner is notified in writing that a professional review action has been proposed to be taken against him/her. The notification includes the reasons for the action and a summary of the appeal rights and process. The practitioner is informed that he/she has the right to request a hearing on the proposed action. The request must be made within 30 calendar days of the date of notification, in writing, directed to the Chair of the CC at the Administrative Office of VCHCP.

Written Notification of Hearing

If a hearing is requested by the affected practitioner, a written notification of the hearing is sent to the practitioner. The notification states the place, time, and date of the hearing. The date of the hearing is not less than 30 or more than 60 calendar days after the date of the notice.

The notification includes a list of the witnesses, if any, that are expected to testify at the hearing on behalf of the CC, the professional review body. The practitioner is also informed that he/she has the right to be represented by an attorney or another person of their choice.

Hearing Panel and Hearing Procedure

The hearing is held before a Hearing Panel. The CC Chair selects and requests the appointment of a Hearing Panel composed of an odd number, at least three (3), of the

practitioner's peers who are not in direct economic competition with the practitioner involved and with current VCHCP agreements but not members of the CC or actively involved in the matter at any previous level.

The CC Chair designates an attorney at law to serve as the Presiding Officer at the hearing. The Presiding Officer may be legal counsel to VCHCP but does not act as the prosecuting officer or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Panel and may be a legal advisor to the Panel but may not vote on the Panel's recommendations. The Presiding Officer is responsible for assuring that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence, and that decorum is maintained throughout the hearing. The Presiding Officer oversees and supervises the entire hearing process and has the sole authority and discretion to rule on all questions such as those pertaining to discovery, procedure, and the admissibility of evidence.

The affected practitioner is required to be personally present at the hearing. The right to the hearing may be forfeited if the practitioner fails, without good cause, to appear. The practitioner has the right to be represented by an attorney or another person of his/her choice. The practitioner must notify the CC Chair at least 14 days prior to the hearing if he/she intends to be represented and if so, the professional status of his representative.

The CC, the body whose actions constituted the adverse recommendation, appoints an individual to represent it as spokesman, and also may be entitled to be represented by an attorney. If the practitioner does not have an attorney present, the CC may not have their attorney present per California law.

During the hearing, both parties have the right to:

- Have a record made of the proceedings and to obtain a copy of that record upon payment of any reasonable charges associated with the preparation of the record.
- Call, examine, and cross-examine witnesses.
- Present evidence determined to be relevant by the Presiding Officer, regardless of its admissibility in a court of law.
- Submit a written statement at the close of the hearing.

The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law. Each party is entitled, prior to or during the hearing, to submit memoranda concerning any issue of law or fact, and those memoranda become part of the hearing record.

The practitioner has the burden of proving by a preponderance of the evidence, that the adverse action or recommendation is arbitrary and capricious. The CC, whose adverse action or recommendation prompted the hearing, has the initial obligation to present evidence in support of its decision, but the practitioner thereafter is responsible for supporting, by a preponderance of the evidence, his/her challenge that the adverse action or recommendation was arbitrary and capricious.

New or additional matters or evidence not raised or presented during the original consideration by the CC may be introduced at the hearing only at the discretion of the Hearing Officer, only if the party requesting consideration of the matter or evidence shows that it could not have been discovered in time for the CC's review. The requesting party shall provide a written substantive description of the matter or evidence to the Hearing Officer and the other party at least three (3) days prior to the scheduled date of the review.

Post Hearing

Within fifteen (15) days after final adjournment of the hearing, the Hearing Panel makes a written report of its findings and recommendations, including a statement of the basis for the recommendations. A copy of its findings and recommendations are sent to VCHCP and the affected practitioner.

If the Hearing Panel's result is favorable to the practitioner, it is effective immediately. If the Hearing Panel's result is not favorable to the practitioner, the decision is forwarded to the CC for review and action. Within fifteen (15) days of the CC's review and action, the affected practitioner is sent written notification of the CC's decision, including a statement of the basis for the decision.

Reporting of Adverse Actions

Reportable adverse actions are those based on a practitioner's professional competence or professional conduct that adversely affects, or could affect, the health or welfare of members. VCHCP reports all adverse actions, which result from professional review action, to the appropriate governmental agencies in accordance with applicable laws, including Medical Board 805, and to the National Practitioner Data Bank (NPDB).

Reports to the NPDB are submitted using the Data Bank website within fifteen (15) calendar days of an adverse action. The Data Bank mails a copy of the processed report to the practitioner named in the report. VCHCP staff mails a printed copy of the Report Verification Document (RVD) to the appropriate state licensing board.

Participation in the HEDIS Quality Measurement Process

"HEDIS", which stands for *"Healthcare 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 search for relevant medical information. The search begins with our administrative systems and may 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 to ensure correct interpretation of the progress notes.

Whether data is obtained through encounter reporting, through claims, through electronic health records or 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. The computerized documentation system, Cerner, will be a major factor in obtaining HEDIS information. Please continue to use and perfect your skills in this system as we move away from paper/hard copy records as is mandated by the Health Care Reform regulations.

Why does VCHCP measure HEDIS? VCHCP is required to report HEDIS rates to its state regulators, the Department of Managed Health Care (DMHC) during the Plan's DMHC medical site audit and for compliance with the DMHC's requirement on Health Equity and Quality Program. Data obtained from HEDIS helps VCHCP to direct its quality improvement activities, evaluate performance, and identify further opportunities for improvement.

Why is this important for members and providers? As a result of measuring health care services, VCHCP can develop initiatives to improve the health of members based upon their health care needs. Quality programs serve to increase member awareness and understanding of preventive health care, health care screenings, and appropriate care for specific conditions. Throughout the HEDIS data collection process, we maintain every member's confidentiality at the highest level. No individual results are reported.

HEDIS TIPS FOR PHYSICIANS

VCHCP may contact selected physicians to review patient medical records as part of the HEDIS medical records review process. The following are HEDIS tips for physicians:

- Physicians should keep accurate, legible, and complete medical records for their patients in their electronic health record documentation system.
- Physicians need to encourage patients to receive appropriate preventive health services to ensure their health and well-being.
- Since HEDIS reporting is mandated for compliance, physicians and their staff should become familiar with HEDIS measures. Doing so will help physicians to better understand the reporting requirements to which health plans are held. Physicians are encouraged to develop a process that will help them identify outstanding preventive health services their patients need at the time patients come in for services. Contractually, physicians are obligated to allow the Plan access for reviewing medical records. VCHCP members sign a medical records

release form at the time of enrollment so it is not necessary for a physician to obtain a release.

Confirmation of Good Standing with State and Federal Regulatory Agencies

All VCHCP-contracted physician providers must maintain a current license with the Medical Board of California (MBC) or the Osteopathic Medical Board of California (OMBC). 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.

Quality Management and Improvement

The Quality Management Program ("QA Program") is an integral part of VCHCP's "Quality and Care Management Program" ("QACMP"). The purpose of the QA Program is to establish objective methods for systematically evaluating and improving the quality, appropriateness, and outcome of care and services, including the structures and processes by which services are delivered to Ventura County Health Care Plan (VCHCP) members. The program is designed to continuously pursue opportunities for improvement and problem resolution. The QA Program incorporates two major processes generally referred to as: Quality Management ("QA") and Quality Improvement ("QI").

The QA Program supports and ensures the organizational mission and strategic goals and processes to ensure quality of care and services are rendered appropriately and safely to all VCHCP members. In so doing, it collaborates with internal and external partners of the organization to ensure the following goals are accomplished:

- To continuously improve the quality of care and service delivered to VCHCP customers, members, employers, and provider panel members.
- To develop, implement and coordinate all activities that are designed to improve the processes by which care and service are delivered.
- To ensure a system of QA communication that is timely and uses appropriate channels to report issues to appropriate individuals (including member communications and provider communications). Topics of communication include, but are not limited to, HEDIS specific measures, Health Plan specific updates (such as Policies and Procedures), and regulatory requirements and updates.
- To facilitate documentation, reporting, and follow-up of QA activities in order to prevent duplication and facilitate excellence in clinical care, service and outcome.
- The evaluation activities include, but are not limited to, the areas of:
    - Provider accessibility and availability
    - Provider satisfaction

- Care guidelines and policies
- All aspects of utilization within the Plan, including under- as well as over-utilization of services.
- Adverse outcomes or sentinel events
- Medical record-keeping practices
- Medical record chart audits
- Provider site audits as part of the credentialing process
- Member satisfaction, including members who have not used the Plan or who have only occasionally used the Plan.
- Complaints, grievances, and appeals.
- Timeliness of handling of claims
- High risk and high-volume services

One of the most important components of the QA Program is the active participation of the VCHCP provider network. The expertise and input of contracted providers are critical to improving the quality of care and service members receive. VCHCP providers serve as members of the committees and ad hoc clinical taskforces. As members of these committees and taskforces, VCHCP providers contribute their knowledge and expertise in analyzing data, identifying barriers, and designing effective interventions to remove those barriers. VCHCP proactively seeks provider participation and encourages providers to volunteer to become active participants in the QA Program.

Providers interested in viewing the Quality Management Program Description in its entirety may access it online at:

http://www.vchealthcareplan.org/providers/medicalPolicies.aspx or by calling Member/Provider Services for a printed copy at (805) 981-5050 or (800) 600-8247.

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Medical Records

To assist us in maintaining continuity of care, physician offices must provide copies of medical records for 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 engaged in care of the member; 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 from the date of the last service or six (6) years from the date that a minor has achieved majority, whichever is later.

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 Joint Commission, and other national credentialing entities.

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

HIPAA Overview

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that requires VCHCP and its providers to protect the security and privacy of its members' Protected Health Information (PHI) and to provide its members with certain privacy rights, including filing a privacy complaint.

PHI is any individually identifiable health information, including demographic information. PHI includes, but is not limited to a member's name, address, phone number, medical information, social security number, Health Plan number, date of birth, financial information, etc.

VCHCP supports the efforts of its providers to comply with HIPAA requirements. Because patient information is critical to carrying out health care operations and payment, VCHCP and its providers need to work together to comply with HIPAA requirements, in terms of protecting patient privacy rights, safeguarding PHI and providing patients with access to their own PHI upon request.

Confidentiality

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 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.

KEY TIPS FOR PROVIDER OFFICES

Member Rights

Under HIPAA, all patients have rights related to their PHI, to which both VCHCP and providers must adhere. The Notice of Privacy Practices outlines VCHCP members' privacy rights and VCHCP's responsibilities. To obtain a copy of the Notice of Privacy Practices, contact the Plan at (805) 981-5050 or (800) 600-8247. Providers should have their own Notice of Privacy Practices. Furthermore, should a VCHCP member want to exercise his or her privacy rights, you may need to request, or advise the patient on how to request, access to his or her PHI from VCHCP.

The succeeding chart lists members' rights with respect to their PHI. Members may exercise any of these rights with respect to PHI held by the provider and/or VCHCP. If the member intends to exercise one of those rights as it pertains to VCHCP, the chart also identifies the specific VCHCP request or authorization form to assist the member.

To obtain a copy of the applicable form, contact Member and Provider Services at (805) 981-5050 or (800) 600-8247

MEMBER RIGHT	VCHCP REQUEST/AUTH FORM
Members can request access to or copies of their PHI, which can include claims reports, care management records, or enrollment information	*Authorization Release Information Form*
Members can request that VCHCP change their PHI records	*Member Request to Amend Protected Health Information (PHI)*
Members can request an accounting of how their PHI was disclosed at VCHCP	*Request for an Accounting of Disclosures Form*
Members can request that VCHCP communicate with them by different ways or to a different address than their home residence	*Request for Restriction on Manner/Method of Confidential Communication Form*
Members can request that VCHCP restrict the use or disclosure of their PHI. VCHCP does not have to agree to the request	*Request for Restriction on Use or Disclosure of Protected Health Information (PHI)*
Members must authorize VCHCP to use or disclose their PHI to another person or authority	*Authorization Release Information Form*

Members must authorize VCHCP to use or disclose their PHI to a family member or friend that is involved in the member's care	*Authorization Release Information Form*

Safeguarding PHI

Both VCHCP and its providers are required by law to protect members' PHI. Providers can take a few basic steps that will significantly minimize the risk of a breach of PHI. The table below contains a few important reminders on how to protect and secure PHI.

PHI in Paper Form	
In the Office	PHI should be locked away during non-business hours
Fax	• Staff should verify fax numbers prior to sending the fax. • Outgoing faxes must include the provider fax cover sheet, which contains a confidentiality statement • Incoming/outgoing faxes should not be left unattended during non-business hours.
Mail	• Quality checks of mailings should be conducted prior to sending. • Envelopes or packages must be properly sealed and secured prior to sending. • Mailings that contain PHI of 2,500 or more members must be sent by a secure bonded courier with a signature required on receipt.
Handling PHI offsite	• PHI must be protected during transport to and from the office through the use of binders, folders or protective covers, or locked in the trunk of the vehicle. • PHI must not be left unattended in vehicles. • PHI must not be left unattended in baggage at any time during traveling.
Disposal	PHI must be shredded or destroyed.

PHI in Electronic Form	
Email	Internal Email: • Email sent within VCHCP or a health network that contains PHI must be limited to the use and disclosure of the minimum necessary data to complete the required message. • Do not include PHI in the subject line of the email.
Electronic Devices	Portable data storage devices (CD's, DVD's, USB drives, portable hard drives, etc.) must be encrypted.
Disposal	PHI in electronic form must be destroyed or disposed of in a secure manner.

Reporting a Breach of PHI

If a provider becomes aware that a breach of PHI has occurred by VCHCP contracted provider or delegate of VCHCP, the provider should notify VCHCP, the delegated entity or provider **immediately** upon discovery. To report a breach to VCHCP, call VCHCP's Member and Provider Services Department at (805) 981-5050 or (800) 600-8247.

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 offices, 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.

If a provider cannot reasonably accommodate a member and requires assistance with access to a provider who can accommodate the member, providers can call Member and Provider Services at (805) 981-5050 or (800) 600-8247 to obtain assistance.

Primary Care Physician Responsibilities

Overview

The Primary Care Provider (PCP) plays the central role in structuring care for the VCHCP members. The PCP is the main provider of health care services for VCHCP members and is responsible for the delivery of health care to his or her assigned members. VCHCP's model of care is built around the PCP, with the PCP as the center of a multidisciplinary team coordinating services furnished by other physicians or providers to meet the needs of the member.

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

The following describes in general the role of the primary care physician:

- Provide care for the majority of health care issues presented by the member, including preventive, acute, and chronic health care.
- Furnish risk assessment, treatment planning, coordination of medically necessary services, referral, follow-up and monitoring of appropriate services and resources required to meet the needs of the members.
- Case management of assigned members to ensure continuity of care, facilitate access to appropriate health services, reduce unnecessary referrals to specialists, minimize inappropriate use of the emergency department, maintain appropriate use of pharmacy benefits, and identify appropriate health education materials and interventions.
- Assure access to care 24 hours per day, seven days per week, including accommodations for urgent care, performance of procedures and inpatient rounds.
- Coordinate and direct appropriate care for members, including:
    - Initial assessments
    - Preventive services in accordance with established standards and periodicity schedules, as required by age and according to the American Academy of Pediatrics (AAP) and the United States Preventive Services Task Force (USPSTF)
    - Second opinions
    - Consultation with referral specialists
    - Follow-up care to assess results of primary care treatment regimen and specialist recommendations.
    - Special treatment within the framework of integrated, continuous care
- Coordinate the authorization of specialist and non-emergency hospital services for members.
- Contact and follow-up with the member when the member misses or cancels an appointment.
- Record and document information in the member medical record, including:
    - Member office visits, emergency visits and hospital admissions
    - Problem lists, including allergies, medications, immunizations, surgeries, procedures and visits
    - Efforts to contact member
    - Treatment, referral, and consultation reports
    - Lab and radiology results ordered by the PCP

- Make reasonable attempts to communicate with the member in the member's preferred language, using available interpretation or translation services.
- If the member has a behavioral health diagnosis, coordinate the member's care with the member's behavioral health provider or behavioral health case manager.
- 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.
- The PCP provides, or arranges for, 24 hour/seven day per week coverage in his or her primary care practice.
- 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-childcare, immunizations, and health screenings.
- 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.
- 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 Utilization Management (UM) Department for approval.
- 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.

Additionally, established guidelines for PCP responsibilities may be reviewed, approved and utilized by VCHCP and distributed to practitioners for use, such as preventive clinical practice guidelines. VCHCP, in conjunction with actively practicing local physicians, also may develop its own description of the primary care physician responsibilities, such as diabetes clinical practice guidelines and asthma clinical practice guidelines.

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.

Affirmative Statement

Utilization management Affirmative Statement

VCHCP distributes the following affirmative statement to all practitioners, providers, staff and members regarding incentives to encourage appropriate utilization and discourage underutilization. The Affirmative Statement is also posted prominently in the UM department.

Ventura County Health Care Plan Affirmative Statement Regarding Utilization-related Incentives*

> UM decision making is based only on appropriateness of care and service and existence of coverage.
>
> The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
>
> Financial incentives for UM decision makers do not encourage decisions that may result in underutilization.
>
> VCHCP does not use incentives to encourage barriers to care and service.
>
> VCHCP does not make hiring, promotion or termination decisions based upon the likelihood or perceived likelihood that an individual will support or tend to support the denial of benefits.

* Includes the following associates: medical and clinical directors, physicians, UM directors and managers, licensed UM staff including management personnel who supervise clinical staff and any associate in any working capacity that may come in contact with members during their care continuum.

VCHCP encourages its providers to practice evidence-based medicine. VCHCP has links to clinical practice guidelines available to address conditions frequently seen in patients at your practice. All clinical practice guidelines included have been reviewed and approved by the VCHCP Quality Assurance Committee.

Recommended Clinical Practice Guidelines and the Link for providers:

- Clinical Practice Guidelines
- Diabetes and Asthma Clinical Practice Guidelines
- Preventive Clinical Practice Guidelines
- Behavioral Health Best Practice Guidelines
  - American Psychiatry Association (APA) Clinical Practice Guideline for Treatment of Depression in Adults
- Non-profit Professional Society, Standards of Care developed by the World Professional Association for Transgender Health (WPATH)

Link to be used: http://www.vchealthcareplan.org/providers/medicalPolicies.aspx.

You may obtain hard copies of the above listed Clinical Practice Guidelines by calling VCHCP at 805-981-5050.

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

Access Standards

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

Contracted providers are expected to comply with these appointment, telephone access, practitioner availability and linguistic service standards. VCHCP monitors its providers for compliance with these standards. VCHCP will develop corrective action plans for providers who do not meet these standards.

Access to Medical Care

Type of Care	Wait Time or Availability
Emergency Services	Immediately, 24 hours a day, seven days a week
Urgent Need – No Prior Auth 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
Family Planning Services	A member shall have direct access to OB/GYN

Waiting time in provider office (to speak to a triage nurse)	30 minutes
Ensure wait time for enrollees to speak with qualified representatives during business hours	Not to exceed 10 minutes

If a timely appointment is not available at any of our contracted clinics/facilities, then an out-of-network (OON) referral request should be sent by the referring provider to the Plan for authorization. The authorization request must include the details regarding the access issue and why an OON referral is required.

Note: The referring provider may allow for an appointment outside of the timely access requirements if it will not be harmful to the patient's health. These instances must be documented in the patient's chart and communicated to the patient.

Other Access Standards

Type of Service	Wait Time or Availability
Telephone Access during normal business hours	A non-recorded answer within 30 seconds (85% of the time) and an abandonment rate of not greater than 5%
Telephone Access after business hours	At minimum, a recorded message that, includes; "If you feel that this is an emergency, hang up and dial 911 or go to the nearest emergency room"
Practitioner After-hours Access	A PCP or designee shall be available 24 hours a day, seven days a week to respond to after-hours member calls or to a hospital emergency room practitioner.
Linguistic Services	Interpreter services are available during business hours through bilingual representatives if Language Attestation Form states provider and/or office staff is bilingual.
Interpreter and Hearing-Impaired Services	There is free access to interpreter services for patients with limited English proficiency and to TTY/TDD or other services for those with hearing impairments. Please see the Plan's Language Assistance Program Description for more information on this.

* If you are unable to obtain a timely referral to an appropriate provider, you can contact the Plan for assistance by calling Provider Services at (805) 981-5050, or via email at VCHCP.ProviderServices@ventura.org

* If you are unable to obtain assistance from the Plan, you also have the right to contact the Department of Managed Health Care (DMHC) at (888) 466-2219 to file a complaint.

Verifying Coverage

Except for emergency services, providers rendering covered services to any VCHCP member should first verify coverage prior to rendering the service. VCHCP does not require a provider to verify a member's eligibility prior to rendering emergency services. A membership card does not guarantee eligibility.

How to Verify a Member is Covered by VCHCP

Verifying the member's eligibility is critical to determine whether a member's enrollment status has changed and to help ensure payment. Providers should contact Member Services at (805) 981-5050 or (800) 600-8247 between the hours of 8:30 am – 4:30 pm, Monday – Friday. If a member is not eligible for benefits on the date of service, then providers will not be paid by VCHCP.

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 ***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.***

Ambulatory Surgeries / Procedures

VCHCP authorization is required for facility and office-based ambulatory surgeries or other 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. 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.

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.

Emergency Services means medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an

emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. Examples of medical emergency situations include uncontrolled bleeding, seizure or loss of consciousness, shortness of breath, chest pain or squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, severe burns, broken bones, or severe pain.

Emergency Services also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility. Examples of psychiatric emergencies include suicidal thoughts, hallucinations, and other mental health emergencies.

An emergency medical/psychiatric condition is one manifesting itself by acute symptoms of sufficient severity such that a person who reasonably believed that an emergency medical/psychiatric condition existed, and could reasonably expect that 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 unborn child and psychiatric conditions leading to danger to self and/or others.

24-hour VCHCP Administrator access is available through Central Communications by calling the Plan's main telephone number, (805) 981-5050, or (800) 600-8247 and selecting the appropriate number (1) for on-call assistance.

Prior authorization is not required for urgent and emergency services. If these services result in a contracted 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. If the hospital or facility is non-contracted, they need to notify VCHCP at the time of the decision to admit. 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 24 hours 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 and attending physician are notified of the determination by phone, fax and/or in writing within 24 hours of decision. The member is notified within 2 business days of decision. The notification includes the initial authorized length of stay or denial of the authorization 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.

Transplant Coverage

Members referred for major organ transplants (including kidney) are evaluated within VCHCP's Transplant Network program as administered by Optum HealthCare. 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.

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 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)

Behavioral Health Services

VCHCP offers Behavioral Health services under a comprehensive program known as "Life Strategies". The *Life Strategies* program is administered by OptumHealth Behavioral Solutions of California (OHBS-CA or Optum) which coordinates the delivery of all mental health and substance abuse services through a unique network of contracted behavioral health providers. VCHCP contracts with Optum for all behavioral health services, Pervasive Developmental Disorder, and Autism Spectrum Disorder.

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.

VCHCP may also delegate UM activities to subcontracted entities. OHBS-CA 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.

Admission and Concurrent Inpatient Review

VCHCP applies industry standard protocols and clinical care guidelines developed by a company known as "Milliman" (MCG), in the admission and concurrent review process. VCHCP Medical Management reviewers may conduct concurrent review throughout admission to determine level of care and continued medical necessity. The reviews are conducted by telephone, fax, or Electronic Medical Record (EMR) review, 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 not at the appropriate level of care, the services may be denied. Only physicians can issue a denial. When applicable, the Medical Director or Physician Reviewer may contact the attending physician to discuss the details of the case. 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.

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. It includes elements of behavioral change and self-management.

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. The goal of VCHCP's Case Management program is to help members regain health and functional capability.

Who Qualifies for Case Management/Members Appropriate for Referral to Case Management? Case Management is provided to eligible members with specific diagnosis or special health care needs. This includes members with complex acute and chronic diagnoses, or specialty care management needs. These members typically require extensive use of resources and need assistance in navigating the healthcare delivery system. Members appropriate for case management referral include those members with medical and psychosocial needs impacting their compliance with disease management and health improvement including increasing severity of condition, safety issues, decreasing functional status, new behavioral health issues, need for caregiver

resources. Services are free and voluntary for eligible members. Members consent to being in the program but can opt out at any time. Being in the program does not affect benefits or eligibility.

How Does Case Management Benefit the Member? Case management provides a consistent method for identifying, addressing, and documenting the health care and social needs of our members along the continuum of care. Once a member has been identified for case management, a nurse will work with the member to:

- Complete a comprehensive initial assessment.
- Determine benefits and resources available to the member.
- Develop and implement an individualized care plan in partnership with the member, his/her physician, and family or caregiver.
- Identify barriers to care.
- Monitor and follow-up on progress toward care plan goals.

How to Make a Referral to Case Management?

If a provider identifies a VCHCP member needing case management, or has questions regarding the Case Management Program, the provider can make a direct referral by contacting VCHCP's Case Management Department at (805) 981-5060, or (800) 600-8247. The VCHCP Case Manager can confirm if the member has an open case management case and works with physician/provider to coordinate the care plan. If a case is not open, the VCHCP Case Manager will confirm member demographics and clinical information to initiate referral through the QNXT module and assist the provider/Physician with care coordination, as appropriate. Members and caregivers can contact Member Services at (805) 981-5050 and request a referral for case management services. Members can also self-refer to the program online on the Member page at https://www.vchealthcareplan.org/members/requestAssistanceForm.aspx click on the box labeled "Request Case Management or Disease Management."

Hospital discharge planning staff may contact the VCHCP Concurrent Review Nurse or VCHCP Case Manager to initiate a case management referral by calling the VCHCP's Case Management Department at (805) 981-5060. The VCHCP Concurrent Review Nurse/VCHCP Case Manager can confirm if the member has an open case management case and works with the Discharge Planner to coordinate care plan. If a case is not open, the Concurrent Review Nurse/VCHCP Case Manager will confirm member demographics and clinical information to initiate referral through the Plan's QNXT module and assist with care coordination, as appropriate.

Please refer to the Complex Case Management policy and procedure located in the provider website:
https://www.vchealthcareplan.org/members/docs/VCHCPComplexCaseManagementPolicyAnd%20Procedure.pdf

Disease Management

The VCHCP Disease Management Program coordinates health care interventions and communications for members with conditions where member self-care can improve their conditions. VCHCP has two Disease Management programs: Asthma and Diabetes. Members with these chronic conditions can come from a systematic process referral source that the Plan has in place to proactively identify members who may be appropriate for Disease Management services. Members, providers, or VCHCP staff can make referrals through the Plan's case management program. The Disease Management team works with doctors and licensed professionals at VCHCP to improve these chronic conditions, so members get the best possible quality of life and functioning. Included in the Disease Management Program are mailed educational materials, provider education on evidence-based clinical guidelines, member education over the phone, and care coordination. VCHCP has a variety of materials about diabetes and asthma that they give to members to help members better understand their condition and manage their chronic disease.

Being in the program is free and voluntary for eligible members. Members can opt out at any time and being in the program does not affect benefits or eligibility.

How to Make a Referral to Disease Management?

For more information or to submit a referral for the Disease Management Program, please call 805-981-5060. Members can also self-refer to the program online on the Member page at https://www.vchealthcareplan.org/members/requestAssistanceForm.aspx and click on the box labeled "Request Case Management or Disease Management".

How and When to Obtain Referrals and Prior Authorizations for Specific Services? From the Plan's Utilization Management?

Providers have the ability to review how and when to obtain referrals and authorization for specific services. They are directed to visit our website at vchealthcareplan.org, click on "Provider Connection", and then click on "Health Services Approval Process." This area offers links for providers to obtain specific information on the Plan's prior authorization process, what services require prior authorization, timelines, and direct referral information.

Here is the link to the Health Services Approval Process:
https://www.vchealthcareplan.org/providers/hsApprovalProcess.aspx

How to Obtain Utilization Management Criteria?

VCHCP Utilization Management uses Milliman Care Guidelines, VCHCP Medical Policies, Express Scripts (ESI) Prior Authorization Drug Guidelines and custom VCHCP Prior Authorization Drug Guidelines as criteria in performing medical necessity reviews. Due to proprietary reasons, we are unable to post the MCG on our website, but a hard copy of an individual guideline can be provided upon request.

A complete listing of VCHCP medical policies and prescription drug policies can be found at: https://www.vchealthcareplan.org/providers/providerIndex.aspx

To obtain printed copies of any of our VCHCP Medical/Drug Policies or Milliman Care Guidelines, please contact Member Services at (805) 981-5050 or (800) 600-8247.

New and updated medical policies are posted on The Plan's website at https://www.vchealthcareplan.org/providers/medicalPolicies.aspx.

Requests for Services/Medical Necessity Determinations

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.

The review of requests for service applies to all requests received by the Utilization Management (UM) department. The UM staff works within their scope of practice, in conjunction with the Medical Director and with the oversight of the UM Committee to review requests appropriately. Appropriately licensed health professionals supervise all review decisions. An RN or licensed physician may review and sign a denial based on benefit coverage. A licensed physician reviews and signs every denial that is based on medical necessity. VCHCP utilizes different types of referrals for VCHCP Members:

- Direct Referral
- Direct Specialty Referral
- Standing Referral
- Prior Authorization

Appropriate medical information should be sent to all consulting providers and to the Health Plan for referrals requiring prior authorization.

Examples of medical information:

- Medical history related to the diagnosis
- Results of any diagnostic tests previously performed (including lab and radiology reports)
- Consultation reports related to the diagnosis from other physicians
- Information on referrals pending for other providers

Direct Referrals

No notification to or authorization by VCHCP is required when the following services are ordered by the member's contracted Primary Care Physician (PCP) and provided by an appropriately contracted Provider. (For current contracted providers, check the Provider Directory, on VCHCP's website):

- Most radiological imaging studies
- Plain x-ray, ultrasound, screening, and diagnostic mammograms

- All radiological imaging studies at VCMC **except** Bone Scan, , Dexa Scan, MRI/MRA/MRV, Myelogram, PET Scan, Tagged White/Red Cell Scan, VQ Scan, and other Nuclear Medicine studies.

Direct Specialty Referrals

Note: Direct Specialty Referral- MUST be referred by the Primary Care Provider except for certain specialties. Neurologists can directly refer to Pain Management Specialists, Physiatrists, and Orthopedics. Pain Management Specialists and Physiatrists can directly refer to Orthopedics. Pain Management Specialists and Physiatrist can refer back and forth based on the type of referral and access.

Neurosurgery can directly refer to Pain Management Specialists, Physiatrists, Neurology and Orthopedics. Pain Management Specialists, Physiatrists, Neurology and Orthopedics can refer back and forth based on the type of referral and access.

Pain Management Specialists and Physical Medicine and Rehabilitation Specialist (PM&R) can directly refer members for pain management injections to Santa Paula Hospital Interventional Radiology.

In addition, urgent care and Emergency Room (ER) physicians may directly refer members to Orthopedics and Cardiology specialties for an urgently required consultation.

All VCHCP contracted specialists can be directly referred to by PCPs using the direct referral form [EXCLUDING TERTIARY REFERRALS (e.g., UCLA AND CHLA)]. Referrals to Physical Therapy and Occupational Therapy also use this form. In addition, referrals to nutritional counseling also use this form.

Direct Referral to Physical Therapy and Occupational Therapy (PT or OT) include an evaluation and additional seven (7) visits up to a total of eight (8) visits. Thereafter, the request for additional visits can come from the physical therapy and occupational therapy providers.

Selected Office Procedures and Services are included in the Direct Referrals and do not require prior authorization. Procedures outside of this designation require prior authorization.

For more details on Direct Specialty Referral, please go to the Plan's website:

www.vchealthcareplan.org

Standing Referrals

VCHCP (The Plan) supports and promotes the provision of standing referrals for members with certain chronic conditions or diseases, including but not limited to HIV and AIDS, which require specialized ongoing care. Primary Care Physicians are able to request:

1. Standing referrals to a specialist for members requiring continuing specialty care over a prolonged period of time, and
2. Extended access to a specialist for an enrollee who has a life threatening, degenerative, or disabling condition that requires coordination of primary care by a Specialty Care Physician (SCP). The SCP is designated to serve as the coordinator of an enrollee's care.

VCHCP supports the development and use of treatment plans to be used in conjunction with the above standing referrals. This treatment plan should be requested using the Plan's Treatment Authorization Request (TAR) form if deemed to be medically necessary by the member's PCP and SCP in question. Treatment plans must describe the course of care. After receiving standing referral approval, the specialist is authorized to provide health care services that are within the specialist's area of expertise and training to the member in the same manner as the PCP. When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, VCHCP will refer the member to an HIV/AIDS specialist who meets California Health and Safety Code criteria. [Ref.: CA Health & Safety Code 1374.16(g)].

If VCHCP does not have an identified HIV/AIDS specialist, the member will be referred to contracted tertiary providers. Determinations based on medical appropriateness are only made by a physician holding an unrestricted license in the State of California. Requests for authorization for standing referrals to specialists are reviewed and the decisions and notifications must be made within the time frames appropriate to the condition of the member (e.g., urgent, non-urgent, concurrent), not to exceed 3 working days of the date after all necessary information is received. [CA Health & Safety Code 1374.16(c)].

PROCEDURE

I. Specialty Referrals

- Requests for standing referrals will be made by the member's PCP, SCP or the member.
- The request will be reviewed and agreed to by the PCP and SCP and submitted to the Plan.
- Standing referral requests include:
  - Member diagnosis
  - Required treatment
  - Requested frequency and time period
  - Relevant medical records
  - Extended Access to Specialty Care
  - The member's PCP or SCP will make a request for extended access to specialty care in which the SCP will coordinate the member's primary care.
  - Requests will indicate life threatening, degenerative, or disabling factors involved in the request.
  - Requests will be reviewed and agreed to by both the PCP and SCP and submitted to VCHCP.
  - The requesting PCP or SCP will indicate the health care services that will be Managed by the SCP and detail those that will be managed by the PCP.

II. Extended Specialty Access Guidelines by Medical Category and Condition

VCHCP provides the PCPs and SPCs the following:

- Process for submission of Standing or Extended Specialist Referral Request to VCHCP. The Treatment Authorization Request Form (TAR) will include the language informing the SPCs of the option to request for a standing referral if they are caring for members who need continuing care and who require care over a prolonged period of time. Additionally, the TAR will contain the information on the timeframe for the length of authorization of standing referrals which is 180 days (see TAR form).
- The Plan's authorization letter will include the 180-day timeframe authorization for standing referrals.
- VCHCP will educate primary care and specialty physicians with regards to AB 1181 and the internal policies and procedures in place to ensure compliance with this legislation.

Services Requiring Prior Authorization

The services listed in the VCHCP Prior Authorization Guide require prior authorization by VCHCP, unless provided on an emergency basis. **These services should not be**

scheduled until final notification of approval is received from the Plan. The Plan reserves the right to deny payment for authorized services if it is determined that inaccurate information was provided to support the Authorization request.

Routine prospective review (prior Authorization) is the process of reviewing elective surgeries, referrals, and ancillary services to evaluate the medical necessity, appropriateness, and benefit coverage of the requested procedure or service.

Definitions

Pre-service decision: Any case or service that the Plan must approve, in whole or in part, in advance of the member obtaining medical care or services. Preauthorization and precertification are pre-service decisions.

Post-service decision: Any review for care or services that have already been received (e.g. retrospective review). A request for coverage of care that was provided by an out-of-network (OON) practitioner and for which the required prior authorization was not obtained is a post-service decision. Although the Plan requires prior authorization of OON care, post-service decisions include any requests for coverage of care or services that a member has already received.

Concurrent review: Any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of treatments. Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care.

In the course of the Authorization review process, the Plan's UM staff uses a wide range of approved criteria, guidelines, and reference tools to assist in the review of medical appropriateness. These include but are not limited to the following resources:

- Milliman Care Guidelines
- U.S. Department of Health and Human Services clinical practice guidelines
- CMS Medicare Program Guidelines, and
- VCHCP Medical/Drug policies
- Up-to-date
- CDC- Centers for Disease Control
- ACIP- Advisory Committee on Immunization Practices
- Non-profit Professional Society, Standards of Care developed by the World Professional Association for Transgender Health (WPATH)

Benefit coverage is determined through Evidence of Coverage (EOC) information and eligibility verification.

Requests for prior authorization must be received from the PCP on a VCHCP Treatment Authorization Request form (available on the website) and be accompanied by all pertinent medical records. Final decision may be delayed if the supporting documents are not provided with the Treatment Authorization Request. Incomplete documentation includes missing or incorrect diagnosis or ICD 10 codes, CPT and HCPCS codes as well as medical necessity information. If the request is urgent or emergent, the UR nurse informs the provider by fax and /or telephone, of the need for such information. If the request is routine, the provider is informed by fax of the need for additional data.

Note that after hour requests for urgent or emergent pre-service and concurrent services are to be received by telephone only.

Submit Prior Authorization Requests to:

VCHCP Attn: UM Department
2220 E. Gonzales Rd. Suite 210B
Oxnard, CA 93036
FAX to: (805) 658-4556 For urgent requests, call: (805) 981-5060

Prior Authorization Review Time Lines:

- VCHCP provides decisions on prior authorization requests in a prompt and timely manner appropriate for the nature of the enrollee's condition.
- Decisions for **routine requests** are not to exceed **five business days** from the Plan's receipt with all information received.
- Decisions for **Urgent requests** are made within **72 hours** from the receipt of request with all information received.
- Decisions for **new prescriptions/medication request** are made within 24 hours from the receipt of request.
- Decisions for **urgent prescription/medication request** are made within 24 hours from the receipt of request.
- Decision for **exigent prescription/medication requests** are made within 24 hours from receipt of request.
- Decisions for **other prescription/medication refills** are made within 24 hours from the receipt of request.
- If approved, a faxed Authorization number is issued. By appropriately identifying referrals as urgent or emergent, the PCP allows the Plan's UM staff to review these in a timely manner. Any services rendered after hours or on weekends, when the UM staff is not available, are subject to retrospective review.

Definitions:

Urgent Service/Care Requests means prompt medical services are provided in a nonemergency situation. Examples of urgent care conditions include sore throats, ear infections, sprains, high fevers, vomiting and urinary tract infections. Urgent situations are not considered to be Emergency Medical Conditions.

Urgently Needed Care/Service Requests means any otherwise Covered Service necessary to prevent serious deterioration of the health of a member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the member is able to see his or her PCP. This includes maternity services necessary to prevent serious deterioration of the health of the member or the member's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee is able to see her Provider.

Emergency/STAT Care/Requests means any otherwise Covered Service that a reasonable person with an average knowledge of health and medicine would seek if he or she was having serious symptoms (including symptoms of Severe Mental Illness and

Serious Emotional Disturbances of a child), and believed that without immediate treatment, any of the following would occur:

- His or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger).
- His or her bodily functions, organs, or parts would become seriously damaged.
- His or her bodily organs or parts would seriously malfunction.

Emergency Care includes paramedic, ambulance and ambulance transport services provided through the "911" emergency response system. Emergency Care also includes the treatment of severe pain or active labor. Emergency Care also includes additional screening examination and evaluation by a Physician (or other health care provider acting within the scope of his or her license) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate such condition, within the capacity of the facility.

Notification

The Health Plan notifies the providers (PCP, Specialist, and/or Facilities; whichever is applicable) via fax of the decision of their Treatment Authorization Request (TAR) within 24 hours of decision for non-urgent and urgent requests. The Health Plan sends approval or denial notification letters to the members via mail regarding the decision of the authorization request within 2 business days of the decision for non-urgent and urgent requests. If the service was denied, the denial letter includes a clear and concise explanation of the reason for denial and a description of the criteria used to deny the request. All letters of denial include a description of how to file an appeal. The returned authorization/decision/TAR form specifies the service authorized, number of treatments, valid from and to dates, and expected length of stay (if appropriate). For questions regarding the status of a prior authorization request, contact VCHCP by phone at (805) 981-5060.

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.

Pharmaceutical Management Procedures

The Ventura County Health Care Plan (VCHCP) offers its members an outpatient prescription medication benefit that includes generic and brand-name medications.

- **List of pharmaceuticals including restrictions and preferences**

VCHCP updates the formulary with changes and gets re-posted monthly in VCHCP's member and provider website. Please refer to the Formulary Drug List posted in the VCHCP provider website:
https://www.vchealthcareplan.org/members/programs/docs/ProviderDrugList.pdf

VCHCP provides a drug plan that includes a Preferred Drug List (PDL) that is based on Express Scripts' "National Preferred Formulary". In addition to the generic and brand name drugs on the PDL, VCHCP also covers many other medications that are classified as "non-preferred". Medications that are not on the PDL, may be available, through a prior authorization process, and usually require a higher co-pay.

VCHCP utilizes a four-tier drug classification system to determine the amount of the patient's cost share, or copayment. Drugs classified as either Tier 1, Tier 2, or Tier 4 constitute VCHCP's Preferred Drug List (PDL). A description of the criteria for the four medication classification tiers follows:

Tier 1 includes all covered generic medications and is available at the lowest copayment to the patient. When appropriate, physicians are encouraged to prescribe generic medications to help patients save money and to help control health care costs. If the patient or physician requests a brand-name medication when a generic is available, in addition to the copay, the patient pays the difference in cost between the brand-name medication and the generic.

Tier 2 includes brand-name medications for which there is generally only a single manufacturing or distributing source. These medications are described in the industry as "single source brands." The patient pays a higher copayment for these than for Tier 1 generic medications.

Tier 3 includes those covered medications considered to be non-preferred. Generally, a medication is considered non-preferred if VCHCP's Pharmacy Benefit Manager (PBM) has determined that there are one or more therapeutically equivalent drug alternatives available to the patient on either Tier 1 or Tier 2. The patient pays the highest copayment amount for these medications.

Tier 4 includes "Specialty Medications" Specialty pharmaceuticals, (primarily injectables), represent a relatively new area of prescription medications, one with a small market in terms of patient populations. Yet it is the single most explosive market in terms of growth and cost. In 2009, VCHCP implemented an integrated approach to managing today's most sophisticated pharmaceuticals. Some of the components include:

- Specialty pharmacy management program, including delivery, pharmacy partnerships and home infusion network coordination to cover all delivery options.
- Utilization analysis and care management to ensure appropriate treatment initiation and continuation.

- Single source for specialty pharmacy efforts to simplify and standardize billing.

Retail Supply (up to 30 days); Mail order (up to 90 days)

2023 MEMBER COST-SHARE – Commercial Benefit Plan		
PREFERRED DRUGS		**NON-PREFERRED DRUGS**
Tier 1	Tier 2	Tier 3
GENERIC	SINGLE-SOURCE BRAND	MULTI-SOURCE BRAND
$9 Retail Copay	$30 Retail Copay	$45 Retail Copay
$18 Mail-Order Copay	$60 Mail-Order Copay	$90 Mail-Order Copay
$18 Retail Copay (Voluntary Smart 90 Program)	$60 Retail Copay (Voluntary Smart 90 Program)	$90 Retail Copay (Voluntary Smart 90 Program)
Tier 4 – Specialty drugs: Generic = 10% (up to $100 max/prescription/month); Brand (preferred) = 10% (up to $250 max/prescription/month); Brand (non-preferred) = 10% (up to $250 max/prescription/month)		

- **Use of Pharmaceutical management procedures**

  For pharmaceutical procedures and updates, please refer to the Pharmacy Program Description on the VCHCP website at THE DRUG BENEFIT PROGRAM OF THE VENTURA COUNTY HEALTH PLAN Here is the link to the website: (vchealthcareplan.org)

- **Generic substitution, therapeutic interchange and step-therapy protocols (Please refer to the formulary drug list posted on VCHCP provider website. Here is the link:**

  https://www.vchealthcareplan.org/members/programs/docs/ProviderDrugList.pdf

GENERIC DRUG POLICY

Specific drugs with generic equivalents should be prescribed and dispensed in the generic form. The generic drug will then be available at the Tier 1 level, with rare exceptions.

Providers are reminded of the following:

1) When generic substitution conflicts with state regulations or restrictions, the pharmacist must obtain approval from the prescribing medical care professional to use the generic equivalent.
2) Pharmacists are reminded that a drug in CAPITALS indicates that one or more (but not necessarily all) forms of the drug are subject to a "Maximum Allowable Cost" or "MAC". In such a case, the pharmacist should consult the MAC list.
3) If a physician indicates "Dispense As Written" ("DAW"), or "Do Not Substitute" ("DNS"), or if a member insists on the brand named product for which an equivalent generic product is available, then the patient must pay the applicable copay plus the cost difference between the brand-name product and the MAC amount.

UNAPPROVED USE OF FORMULARY MEDICATIONS

Medications are generally covered only if they are FDA-approved medications and are used for non-experimental indications. Non-experimental indications include the labeled indication(s) (FDA-approved) and other indications accepted as effective by the balance of currently available scientific evidence and informed professional opinion. This so-called "off-label" use may place the medication in a higher tier for purposes of determining the copay, or it may be that such use is not a covered treatment, under any condition, in which case the member will bear the entire cost of the prescription.

STEP THERAPY (ST)* Please refer to the Step Therapy Policy posted on the VCHCP provider website. Here is the link:

https://www.vchealthcareplan.org/providers/docs/padg/steptherapy/StepTherapyCheatSheet.pdf

In collaboration with Express Scripts, VCHCP has implemented step therapy programs for several different classes of drugs for which specific medications, designated as Step 2 drugs, will only be approved after a trial of Step 1 medications have been documented or under certain other conditions. Example of classes of medications covered by this program include Angiotensin Converting Enzymes (ACE), Angiotensin Receptor Blockers (ARBs), Brand Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), COX 2

inhibitors, Proton Pump Inhibitors (PPIs), Selective Serotonin Reuptake Inhibitors (SSRIs), Other Antidepressants (SNRIs), Cholesterol Lowering medications (statins) and certain diabetic medications. See the most recently approved Step Therapy Program for details.

*If an exception from the step therapy protocol is sought, prior authorization should be obtained. If a physician or member insists on non-authorized use of a step therapy drug, the member will be responsible for 100% of the prescription cost.

- **Limits and Quotas (Please refer to the DQM documents provided on the provider website.**

Here is the link:
https://www.vchealthcareplan.org/members/programs/docs/DQMLimited.pdf

https://www.vchealthcareplan.org/members/programs/docs/DQMAdvantagePlus.pdf

https://www.vchealthcareplan.org/members/programs/docs/DQMAdvantage.pdf

DRUG QUANTITY LIMITS (DQMs)

Some formulary medications have a Quantity Limit (QL) which is applied against the written prescription. These are designated with QL on the formulary list, corresponding to the Drug Quantity Management program adopted from the Plan's Pharmacy Benefit Manager, Express Scripts (ESI). If, for instance, the number of doses of a certain drug exceeds the QL, then the member will receive only the allowed number, as shown in the QL list. With some exceptions, QLs are generally the amount allowed over a thirty (30) day period when purchased at a participating pharmacy, or for ninety (90) days if purchased by mail order. (It should be noted that not all drugs are available through mail order**.** In particular, injectable drugs and drugs for insomnia, erectile dysfunction, and headaches may not be available by mail order.)

EXCLUDED MEDICATIONS

Certain medications are specifically excluded from coverage, as noted in the EVIDENCE OF COVERAGE. These include dietary supplements, cosmetics or medications used for cosmetic purposes (i.e. retinoic acid for wrinkles), and medications to treat baldness.

A few drugs are specifically excluded because they are not included in a competitive pricing category (CPC). In each case, alternative drugs are available in that therapeutic category. These excluded drugs are therefore not covered by the Plan.

COPAY DETERMINATION - COMMERCIAL BENEFIT PLAN

The table below describes the copay which will be charged to the patient when filling a prescription. (See above "Generic Drug Policy" for additional conditions and payments which apply when certain non-generic drugs are provided.)

	Type of Prescription	Member's Co-Pay	Comments
1.	Generic formulation is available and furnished by a network pharmacy.	Tier 1 $9	$18 (if a 3-mo. supply by mail – Mail-Order Copay) $18 (if a 3-mo. supply via retail through voluntary Smart 90 Program – Retail Copay)
2.	Preferred Drug but only brand-name or single-source is available.	Tier 2 $30 or more	$60 (if a 3-mo. supply by mail– Mail-Order Copay) $60 (if a 3-mo. supply via retail through voluntary Smart 90 Program – Retail Copay)
3.	Non-Preferred Drug except if excluded. (See excluded drugs.) Certain drugs must be prior authorized before the prescription will be covered by the Plan.	Tier 3 $45 or more	$90 (if a 3-mo. supply by mail– Mail-Order Copay) $90 (if a 3-mo. supply via retail through voluntary Smart 90 Program – Retail Copay)
4.	Brand Drug for which a generic preparation is available, but physician and/or member requests the brand rather than the generic.	Member pays, in addition to copay, difference in cost between generic and brand drug, up to 100% of cost of brand drug	Tier 3 copay
5.	Over the counter (OTC) preparation when the equivalent drug is available as a prescription drug and is equal in dosage.	Member pays full cost if the OTC strength of the drug and the strength of the drug by prescription are the same	Although a physician may have written the prescription, this is not a covered benefit if the drug is available OTC at the same strength.

	Type of Prescription	Member's Co-Pay	Comments
6.	Drugs for treatment of non-covered conditions.	Member pays full cost	Regardless of a drug being on or off the PDL, if a drug is prescribed for a non-covered condition, the member pays full cost.
7.	Investigational Drugs: FDA approved for retail sales, but investigation is for treatment of medical diagnoses not otherwise approved by the FDA (or not supported by informed medical opinion or the peer reviewed medical literature).	Tier 3 copay or actual drug cost	Can only be prescribed for the specific investigation of a condition(s) covered under the Plan; requires prior authorization.
8.	Not FDA approved for retail sales, but is in a formally approved study, (phase II or greater).	Actual drug cost	Not covered by the Plan.

	Type of Prescription	Member's Co-Pay	Comments
9.	All "specialty" medications, including injectables (see exception below) used for the treatment of chronic conditions (other than diabetes), such as hepatitis C, multiple sclerosis, rheumatoid arthritis, and HIV/AIDS. Please see the Plan's Specialty Medication Program Description at the Provider Connections website at www.vchealthcareplan.org for more information. VCHCP utilizes Accredo, a division of Express Scripts, to manage our specialty medication program.	Tier 4 Generic = 10% (up to $100 max/prescription/month); Brand (preferred) = 10% (up to $250 max/prescription/month); Brand (non-preferred) = 10% (up to $250 max/prescription/month)	All injectables (see exceptions below) require prior authorization and may also be subject to certain Drug Quantity Management Limits (DQM). (Does not include injectable(s) given during an office visit.) For the current QL list (at the time of publication) please see the PA/DQM/ST list on each page. Includes pharmaceuticals covered and managed through VCHCP's medical benefit. These drugs are primarily used in conjunction with in-office and medical procedures which require pre-authorization and are reviewed through VCHCP's medical management processes.

All questions and/or requests regarding the Formulary can be address by Express Scripts at 888-327-9791 or online at: https://www.express-scripts.com/corporate.

All questions and/or requests regarding pharmaceuticals covered and managed through VCHCP's medical management process can be addressed by Ventura County Health Care Plan by calling 805-981-5050 or to request a prior authorization online, please complete the pharmacy request form with instructions located in the Plan's website: https://www.vchealthcareplan.org/providers/docs/PrescriptionDrugPriorAuthorizationRequestForm.pdf

Please refer to the Pharmaceutical Medication Benefit Program Description Policy and Procedure:
https://www.vchealthcareplan.org/members/programs/docs/PrescriptionMedicationBenefitProgramDescription.pdf

- **Exception Request**

SUBMITTING EXCEPTION REQUESTS TO THE PREFERRED DRUG LIST

Members can request individual exceptions to the preferred drug list through their primary care practitioner or directly to VCHCP by phone or through the VCHCP website. Practitioners can then submit a Prior Authorization (PA) Request on the member's behalf to VCHCP for consideration. Practitioners may themselves also initiate a petition for consideration of coverage. Practitioners should include relevant clinical history, previous medications prescribed and tried, contraindications or allergies to medications and any other contributory information deemed useful. VCHCP will review the information according to the PA policy. Because the PA requests are reviewed by the Plan and not the PBM, if the medication does not meet criteria on initial review by the nurse reviewer, it is reviewed by a physician reviewer and special consideration is given to the exception request based on the information received. The physician reviewers are also available by phone to discuss an exception request with the practitioner.

SUBMITTING AN EXTERNAL EXCEPTION REVIEW REQUESTS FOR THE DENIAL OF REQUEST FOR STEP THERAPY EXCEPTION, FORMULARY EXCEPTION, AND PRIOR AUTHORIZATION

An enrollee, an enrollee's designee, or a prescribing provider can request that the original step therapy exception request, formulary exception request, prior authorization request and subsequent denial of such requests be reviewed by an independent review organization by following the steps below:

- Submit an external exception via online request available in the VCHCP member website (https://vchealthcareplan.org/members/requestPharmacyExceptionForm.aspx) or by calling the Plan.
- Ask the Plan to make an external exception to its coverage rules.
- There are several types of exceptions that can be requested such as:
    - Cover a drug even if it is not on the Plan's formulary.
    - Waive coverage restrictions or limits on a drug. For example, the Plan limit the amount on certain drugs it covers. If the drug has a quantity limit, ask the Plan to waive the limit and cover more.
    - Provide a higher level of coverage for a drug. For example, if the drug is in the Non-Preferred Drug tier, ask the Plan to cover it at the cost-sharing amount that applies to drugs on the Preferred Brand Drug tier 3 instead. This applies so long as there is a formulary drug that treats your condition on the Preferred Brand Drug tier 3. This would lower the amount paid for medications.

- Once the Plan receives the external exception request via website or via phone call, the Plan's Utilization Management will contact your doctor to process your External Exception Review Request.
- The Plan sends your external exception review request to an independent review organization (IRO) called IMEDECS/Kepro
- VCHCP will ensure a decision and notification within 72 hours in routine/standard circumstances or 24 hours in exigent circumstances.
- The Plan will make its determination on the external exception request review and notify the enrollee or the enrollee's designee and the prescribing provider of its coverage determination no later than no later than 24 hours following receipt of the request, if the original request was an expedited formulary/prior authorization/step therapy exception request or 72 hours following receipt of the request, if the original request was a standard request for nonformulary prescription drugs/step therapy/prior authorization.
- If additional information is required to make a decision, the Plan in collaboration with IMEDECS/Kepro will send a letter via fax to your prescribing doctor advising that additional information is required.
- External exception review request for step therapy/nonformulary/prior authorization will be reviewed against the criteria in Section 1367.206(b) and, if the request is denied, the Plan will explain why the external exception request for step therapy/nonformulary/prior authorization drug did not meet any of the enumerated criteria in section 1367.206(b).
- The enrollee or enrollee's designee or guardian may file a grievance seeking an external exception review request when the Plan disapproves a provider's request for authorization of a medically necessary non-formulary prescription drug. The external exception review may be initiated through the Plan's grievance process.
- For disapproved medically necessary non-formulary prescription drugs, the enrollee has the right to participate in the Plan's grievance process in addition to filing a grievance seeking an external exception review request.
- The external exception request review process does not affect or limit the enrollee's eligibility for independent medical review or to file an internal appeal with VCHCP. The enrollee or enrollee's designee or guardian may appeal a denial of an external exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request by filing a grievance under Section 1368.
- If the independent review organization (IRO) reverses the denial of a prior authorization, formulary exception, or step therapy request, the decision is binding on the Plan.
- The decision of independent review organization (IRO) to reverse a denial of a prior authorization, formulary exception, or step therapy request applies to the duration of the prescription including refills.

The timeline for prior authorization decisions for formulary exception request process are as follows:

The Plan processes requests for prescriptions according to the following timelines:
• For new prescriptions: Within 24 hours of the Plan's receipt of the request.
• For exigent circumstances: Within 24 hours of the Plan's receipt of the request.
• For urgent refills: Within 24 hours of the Plans receipt of the request.
• For other refills: Within 24 hours of the Plans receipt of the request.

ANNUAL REVIEWING AND UPDATING OF PROCEDURES

The VCHCP Pharmacy and Therapeutics Committee (P&T Committee) meets quarterly and, at least annually, reviews and updates, as appropriate, the Pharmaceutical Management policies and procedures. The formulary is reviewed semiannually, initially through ESI Pharmacy & Therapeutics Committee and subsequently through the VCHCP Pharmacy & Therapeutics Committee and updated as appropriate. Procedures and the formulary may also be updated on an ongoing, as needed basis when new pharmaceutical information is received or requested by members, pharmacists, practitioners, or other sources, using the expertise of the PBM. Updates to the formulary outside of the semi-annual review are added to the formulary on the website. If the formulary change is a "negative" formulary update, this is communicated by ESI via mail to the affected members. A list of affected members is sent to VCHCP medical management staff who notify prescribing practitioners by phone of the change to the formulary and offer alternatives.

The most up-to-date ESI website formulary information is accessible to members and providers at www.express-scripts.com and through a link on the VCHCP website at www.vchealthcareplan.org. For any other inquiries, call Express Scripts at 800-753-2851.

PRIOR AUTHORIZATION PROGRAM

POLICY**:**

Prior authorization is the utilization review process to determine whether a requested prescription drug meets VCHCP's clinical criteria for coverage.

Using a tiered system, most medications on Tiers 1, 2 and 3 are available by proper prescription from the physician to the Plan member. These prescriptions, whether for preferred or non-preferred drugs as set forth in the Plan's Preferred Drug List (PDL), are filled upon presentation of a valid prescription at a participating pharmacy. There are, however, certain medications that require Prior Authorization (PA). The Pharmacy and Therapeutics (P&T) Committee may designate any preferred or non-preferred medication as requiring PA by the Plan. Generally, these medications are high-cost medications or medications for which medical necessity must be demonstrated. These are so labeled and documented in the PDL. Prior authorization encourages the appropriate and cost-effective use of a drug by allowing coverage only when certain conditions are met. The PDL has been compiled by the Pharmacy Benefit Manager (PBM) after extensive research and adopted by VCHCP's P&T and Quality Assurance (QA) Committees using, in part, current medical findings, FDA-approved manufacturer labeling information, pharmaceutical class coverage and medication availability to treat disease and medical

conditions. Additionally, the PDL is regularly reviewed with additions and deletions made as appropriate.

Please see the Plan's Prescription Medication Benefit Program Description and the Prior Authorization of Medication Program Policy (they can be found at the Provider Connections section of our website at www.vchealthcareplan.org) for more information on specific drugs or drug classification that require prior authorization. Prior authorization is not required for non-preferred drugs based on their non-preferred status alone. However, the Plan, upon review with the P&T Committee, may institute prior authorization criteria for specific drugs.

PROCEDURE:

Submissions:

When a physician requests a medication that has a prior authorization (PA) requirement, the pharmacy or the prescribing physician must contact the Plan explaining the medical necessity of the request, including past therapeutic attempts, contraindications to medications and allergies when applicable.

Requests for authorization during regular business hours may be made by telephone, in writing, or by facsimile by the pharmacy or the prescribing physician to the Plan. The DMHC approved pharmacy prior authorization form is available for submission convenience. Requests for emergency authorization during regular working hours are handled by the Plan's UM staff.

Requests for emergency authorization after regular business hours are to be made by telephone by the pharmacy or the prescribing physician to the Plan's voice mail system which connects the caller to the Plan's answering service, available 24 hours a day, 7 days a week. The service will contact the Plan Medical Director and/or designated Administrator on call having the authority to approve medications requiring prior authorization.

Timelines for Decisions:

The Plan processes requests for prescriptions according to the following timelines:

- For new prescriptions: Within 24 hours of the Plan's receipt of the request.
- For exigent circumstances: Within 24 hours of the Plan's receipt of the request.
- For urgent refills: Within 24 hours of the Plans receipt of the request.
- For other refills: Within 24 hours of the Plans receipt of the request.

"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.

"Urgent" means any otherwise Covered Service including medications necessary to prevent serious deterioration of the health of a member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member is able to see his or her PCP.

Review/Decision Making:

The Ventura County Health Care Plan (VCHCP) policy is that the Medical Management (MM) staff may apply the adopted criteria to approve drugs requiring prior authorization. All requests that do not meet criteria are referred to the Medical Director or his/her designee for a decision.

The VCHCP Medical Director or Utilization Review physician approves or denies all requests for prior authorization of Preferred or Non-Preferred Drug List medications that do not meet the prior authorization criteria established by the Pharmacy & Therapeutics Committee.

The Medical Director or his/her designee may do any or all of the following before making a coverage decision for a requested medication requiring prior authorization:

- Review Pharmacy and Therapeutics Committee criteria for prior authorization of medication in question.
- Review patient medical records that document the need for the requested drug, the efficacy of any sample medications tried, and the contraindications or ineffectiveness of other drugs tried, including allergies.
- Review correspondence from the prescribing physician supporting the requested drug.
- Review the patient's prescription drug usage history under the Plan.
- Review written information about the requested drug provided by the Plan's pharmacy benefit manager, in Up-to-date or any other source of reliable information or provided by the drug manufacturer.
- Contact the following individuals for additional information to support the medical necessity of the request.
    - the prescribing physician
    - a qualified clinical pharmacist (with at least 3 years clinical experience or completion of a pharmacy residency) or
    - a qualified physician (a board-certified physician with special training or expertise in an area related to the proposed use of the drug)

When the authorization is approved, the Plan's Medical Management (MM) staff either enters the authorization in the PBM's network system or contacts the PBM's customer service representative by phone, who then enters the authorization in the PBM's network system. The Plan's MM staff completes the authorization process in its medical management/documentation system, known as QNXT, where a fax approval notification is created and faxed to the provider and a member approval letter is created and mailed to the member.

When the request for prior authorization comes from the dispensing pharmacy, the Plan's MM staff informs the dispensing pharmacy via phone that authorization for the medication is in place.

When an authorization is denied, the denial shall be made in writing to the member and to the prescribing physician and will include the following information:

- Reason for the denial
- Any alternative drug or treatment offered by the Plan.
- Information to the members regarding the Plan's Appeal process.
- Information to the member regarding the Independent Medical Review (IMR) process if the drug is denied because it is experimental or investigational.
- Name and contact information for person who made the denial decision.

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. Further information regarding billing procedures and requirements for submitting claims is located on VCHCP's website at www.vchealthcareplan.org/Provider Connection/Provider Disclosures.

Claims Submission

Electronic Submission

Providers may submit their claims electronically through Office Ally, a claims clearinghouse, at no charge. The Plan's Payer ID for Office Ally is 'VCHCP'. For information regarding how to contact Office Ally, you may call the VCHCP Member/Provider Services Department at (805) 981-5050, VCHCP.ProviderServices@ventura.org, contact Office Ally directly at (360) 975-7000, 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 "clean" claim form. A clean claim is a complete and accurate claim form that includes all provider and member information, as well as records, additional information, or documents needed from the member or provider to enable the Plan to process the claim. When billing medical claim forms, the UB04 (CMS 1450) is used by hospitals and other facility providers. 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). The Centers for Medicare and

Medicaid (CMS) 1500 Form adopted by the National Uniform Claim Committee (NUCC) is used by health care professionals and suppliers. The Plan does not supply claim forms to providers. Providers should purchase these forms from a supplier of their choice.

For paper claim submission please follow these guidelines to ensure that the claim is processed without delay or rejection:

- Use original red print UB-04 (CMS-1450) and CMS 1500 paper forms only. Do not submit copies.
- Complete all required data fields.
- Ensure submission of complete patient detail. Include the VCHCP Member Identification (ID) number, last name and date of birth (as indicated on the member's VCHCP ID card). Each VCHCP member is assigned a unique member ID number.
- Use Industry Standard Procedure Codes. Services must be reported using the industry standard coding of Current Procedural Terminology™ (CPT) and/or Healthcare Common Procedure Coding Systems (HCPCS), including modifiers. Codes that have been deleted from CPT or HCPCS are not recognized. For Not Elsewhere Classified (NEC) or Not Otherwise Classified (NOS) Codes, providers should always bill a defined code when one is available. If one is not available, use an unlisted service (NEC or NOS), and provide a description of the service along with office and/or operative notes.
- The Plan does not accept Medi-Cal codes. Usage of Medi-Cal codes will result in denial of the claim.
- Use Industry Standard Diagnosis Codes. The diagnosis must be reported using Internal Classification of Disease 10th revision, Clinical Modification (ICD-10-CM). ICD-10 diagnosis codes are to be reported at the highest number of characters available.
- For UB-04 claims, use industry standard revenue codes.
- Submit valid service dates. Do not bill for future dates of service; these claims will be rejected.
- Service units are required.
- Enter valid place of service codes.
- The total billed charges amount must equal the amounts of the service detail lines.
- Replacement/corrected UB-04 claims require a Type of Bill with Frequency Code "7" (third digit in Type of Bill) and claim number in Field 64 (Document Control Number).
- For corrected or replacement CMS 1500 claim forms a "7" should be billed in box 22 of the claim form. The Plan's original claim number should also be included in box 22 under the "ORIGINAL REF NO." field.
- Corrected claims should be submitted with all line items completed to reflect all services rendered, and not just billed with only the lines items that need to be corrected.
- Usage of Frequency Code 7 signifies that the information present on the claim represents a complete replacement of the previously submitted claim. A corrected

claim is a replacement of a previously billed claim that requires a revision to coding, service dates, billed amounts, or member information.

VCHCP uses optical character recognition (OCR) to scan paper claims. Claims submitted on photocopied claim forms prevent the OCR process from working properly, necessitating manual data entry or rejection of the claim, which can slow down processing and payment. To ensure all claims are processed against the same requirements, paper claims are converted to an electronic format. However, system limitations can cause data elements to be misinterpreted during the conversion process. Follow these guidelines to ensure your claims are successfully converted:

- Do not include stamped or handwritten data or comments anywhere on the claim form. To include comments, use the claim remarks fields on the UB-04 (field 80) and Box 19 on the CMS-1500. If additional space is required, please attach the documentation to the claim form.
- Do use standard fonts and sizes.
- Do not print claim data outside of the designated field.
- Use black printer ink only. Do not use highlighters or markers.
- Do not send printed claims that are illegible, including print that is too faint to read through OCR. This may cause your claim to be rejected (returned for resubmission).
- All patient details are required (ID number with prefix, last name, first name, and date of birth). Separate the subscriber/patient's last name and first name with a comma.
- Do not send double-sided printed claim forms. Paper claims exceeding six detail lines or other excessive data elements should be sent on a separate page.

Please send claims to:

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

Reference Materials

Reference materials are available to ensure appropriate coding. Various types of codes and descriptions of their usage in submitting claims are listed below.

Correct Coding

Correct coding is key to submitting valid claims. To ensure claims are as accurate as possible, use current valid diagnosis and procedure codes and code them to the highest level of specificity (maximum number of digits) available.

On October 1, 2015, the healthcare industry in the United States retired the ICD-9 code set and began using ICD-10 codes when submitting claims. As discussed in the following section this change affected both institutional and professional claims.

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. The ICD-9-CM coding system is to be used when billing service dates prior to October 1, 2015. Refer to the section titled "ICD-10-CM (International Classification of Diseases) Codes" for further information regarding the usage of ICD-9-CM and ICD-10-CM.

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

For service dates on or after October 1, 2015, Ventura County Health Care Plan (VCHCP) transitioned to accepting and processing claims with the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) coding system as mandated by the U.S. Department of Health and Human Services to replace the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) coding system.

Claims submitted to VCHCP with service dates of October 1, 2015 and after must meet the ICD-10-CM/ICD-10-PCS guidelines outlined below regardless of paper or Electronic Data Interchange (EDI) submission avenues.

Outpatient Services

- **Institutional claims:** Submit diagnosis codes on claims with service dates of 10/01/15 and after using ICD-10-CM.
- **Professional claims:** Submit diagnosis codes on claims with service dates of 10/01/15 and after using ICD-10-CM.

Inpatient Services

- **Institutional claims (diagnosis codes):** Submit diagnosis codes on claims with service dates of 10/01/15 and after using ICD-10-CM.
- **Institutional claims (procedure codes):** Submit procedure codes on claims with service dates of 10/01/15 and after using ICD-10-PCS.

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) Codes

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 Common Procedure Coding System)

HCPCS (Healthcare Common 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), based upon provider's purchased package size, as set forth in a nationally recognized pricing source When billing *for any covered new drugs or unclassified drugs, Provider must bill using the appropriate revenue code and non-specific J Code (HCPCS) such as J3490 or J9999 with the drug name, dosage, and strength, method of administration, NDC, and basis of measurement in order to receive payment. A non-specific 'J' (HCPCS) code should be used only when another "J' code does not describe the drug being administered, for example, if CMS hasn't assigned a specific code to the drug. These drugs may require physician review and authorization by VCHCP.* A pharmaceutical invoice may be required to establish cost to determine reimbursement for any new, unclassified, or otherwise covered drug without Medicare ASP drug pricing. Refer to your provider services agreement for more specific information.

Billing Medroxyprogesterone Acetate (Depo-Provera), 1 mg (J1050 vs J3490)

The Plan accepts HCPCS code J1050 when injecting medroxyprogesterone acetate (Depo-Provera), 1 mg. For contraceptive usage a total of 150 units should be entered for HCPCS code J1050 with a contraceptive management diagnosis included on the claim. CPT code 96372 (injection of drug under skin or into muscle) may be billed in combination with J1050. Do not substitute HCPCS code J3490 (unclassified drug) for J1050, this will result in denial of the service.

Anesthesia

For questions regarding medical necessity for monitored anesthesia care, refer to the Plan's Medical policy at www.vchealthcareplan.org, Provider Connection/Medical Policies/Policy for Outpatient Monitored Anesthesia Care.

Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance; that is, when the patient is safely placed under post-anesthesia supervision.

For anesthesia codes: 01953, 01996, 99100, 99116, 99135, 99140, time units are not a factor. The allowed amount will be calculated using ASA base unit values (BUVs) multiplied by the anesthesia rate. To report moderate (conscious) sedation provided by a physician also performing the service for which conscious sedation is being provided, see codes 99151, 99152, 99153. Consultations and/or other evaluation and management services which are not included in the administration or supervising the administration, regardless of location provided, are reported using evaluation and management CPT codes. For contracted providers, please refer to your provider services agreement for additional information regarding billing guidelines and reimbursement.

VCHCP requires the use of the following anesthesia modifiers when applicable:

-23: Unusual anesthesia (requires prior authorization or physician review and operative notes (and/or office notes are required).

-47: Anesthesia by surgeon (informational).

-AA: Anesthesia service performed personally by anesthesiologist (unusual circumstances when it is medically necessary for both the CRNA and anesthesiologist to be completely and fully involved during a procedure). Anesthesiologists would report -AA and CRNA-QZ.

-QK: Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals.

-QS: Monitored anesthesia care services.

-QX: CRNA service: with medical direction by a physician.

-QY: Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist.

-QZ: CRNA service.

Anesthesia Physical Status Modifiers (report when applicable):

-P1: A normal healthy patient.

-P2: A patient with mild systemic disease.

-P3: A patient with severe systemic disease (BUV = 1).

-P4: A patient with severe systemic disease that is a constant threat to life (BUV = 2).

-P5: A moribund patient who is not expected to survive without the operation (BUV = 3).

-P6: A declared brain-dead patient whose organs are being removed for donor purposes.

Qualifying Circumstances for Anesthesia:

In the case of difficult and/or extraordinary circumstances such as extreme youth or age, extraordinary condition of the patient, and/or unusual factors it may be appropriate to report one or more of the following qualifying circumstances in addition to the anesthesia services. List these codes separately in addition to code for primary anesthesia procedure:

- 99100/Anesthesia for patients of extreme age, younger than one year and older than 70.
- 99116/Anesthesia complicated by utilization of total body hypothermia.
- 99135/Anesthesia complicated by utilization of controlled hypotension.
- 99140/Anesthesia complicated by emergency conditions (specify). An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part). When billing this code, medical records may be required for physician review.

Modifiers (CPT and HCPCS):

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS).

Modifiers provide a way to indicate that the services or procedure has been altered by some specific circumstance but have not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are: To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery. To indicate that a procedure was performed bilaterally. To report multiple procedures performed at the same session by the same provider. To report only the professional component or only the technical component of a procedure or service. To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit). To indicate special ambulance circumstances.

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers are not intended to be used to report service that are “similar” or “closely related” to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation, and use the unlisted code closest to the section which resembles the type of service provided to report the service.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

VCHCP requires these two-digit modifiers to report that a service or procedure has been "altered or modified be some specific circumstance" without altering or modifying the basic definition or CPT code:

-22: Increased Procedural Services – An operative report containing documentation substantiating increased complexity and/or time is required for physician review Providers are also required to submit a separate written statement explaining the outlying circumstances that support appending modifier 22 to the procedure code. All CPT codes have a level of complexity. When a service performed has exceeded the normal level of complexity modifier 22 can be appended to the procedure code to define increased procedural services and demonstrate when a physician has gone above and beyond the typical requirements of a particular procedure. If appropriate, modifier 22 can be used to reimburse the physician for unforeseen difficulties or additional time spent that is not usually required for the procedure. Modifier 22 should only be appended for outlying circumstances when the physician spent significantly greater time, energy, and resources to perform. When approved, standard reimbursement will be 120% of the provider's allowable fee. Providers seeking compensation above the standard reimbursement must request the desired amount within the written statement explaining the outlying circumstances supported by the operative report.

-23: Unusual Anesthesia – Physician review and/or office notes is required. Modifier 23 should only be appended to an anesthesia code when the provider administers general anesthesia for a procedure that does not normally require it.

-24: Unrelated Evaluation and Management Service by the same physician during a postoperative period (informational). This modifier may be used to indicate that an evaluation and management (E/M) service or eye exam, which falls within the global period of a major or minor surgery and which is performed by the surgeon, is unrelated to the surgery. If the diagnosis for the E/M service clearly substantiates that the visit was unrelated to the surgery medical record documentation is not required.

-25: Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service. Claims are subject to review if there is any question about the E/M being significant and separately identifiable. Office/clinical notes may be requested. If a significant, separately identifiable evaluation and management (E/M) service is performed during a well patient examination by the same physician modifier 25 should be appended to that code.

-26: Professional Component (Utilized when charge for the physician component is reported separately.) Reimbursement is based on the fee schedule allowable for the professional component only. Modifier 26 is appended to billed codes to indicate that only the professional component of a service/procedure has been provided. For example, most radiology codes are eligible to be reported with modifier 26 when the provider does not perform the service but interprets the results.

-27: Multiple outpatient hospital evaluation and management encounters on the same date. May require medical record review. Modifier 27 is for hospital/outpatient facilities to use when multiple outpatient hospital E/M encounters occur for the same member on the same date of service. Modifier 27 is exclusive to hospital outpatient departments, including hospital emergency departments, clinics, and critical care.

-33: Preventive Service – Modifier 33 is reported to commercial payors only and is appended to appropriate codes not already designated as preventive services to represent a preventive service as defined in accordance with the U.S. Preventive Services Task Force (USPSTF) with a grade of either A or B in effect at the time of service. Appropriate diagnostic codes identifying screening/preventive services must also be reported to support modifier 33. Do not report modifier 33 when billing diagnostic services. Cost sharing will not be applied to eligible services reported with modifier 33.

-47: Anesthesia by surgeon – Informational only. This modifier may be submitted when the operating surgeon performs the anesthesia service (does not include local anesthesia). Add CPT modifier 47 to the basic service for a regional block or general anesthesia provided by the surgeon.

-50: Bilateral Procedure – Reimbursement will be 150% of the allowed amount for surgical procedures unless otherwise specified within your contract. For bilateral surgical procedures when there is no specific bilateral procedure code available to bill the service with, use the appropriate CPT code for the service, and modifier 50. Indicate one unit in the unit field of the claim line. Do not use modifier 50 on a bilateral procedure performed on different areas of the right and left sides of the body. Do not report bilateral procedures as two separate claim line items. Do not report modifier 50 for procedures that are inherently bilateral. If bilateral procedures are reported with other procedure codes on the same day, multiple surgery procedure adjustments apply as usual in addition to the bilateral payment adjustment. Other payment adjustments (e.g., assistant surgeon, related procedure within postoperative period, multiple procedure reductions, etc.) also apply, when appropriate: A multiple procedure reduction of 50% will apply to all bilateral procedures subject to multiple procedure discounting.

-51: Multiple Procedures – Reimbursement will be 50% of the allowed amount for surgical procedures billed with modifier 51, unless otherwise specified within your contract. Payment is based for each ranked procedure at:

- 100 percent of the fee schedule amount for the highest valued procedure contingent upon application of other eligible reimbursement modifiers.
- 50 percent of the fee schedule amount for the second highest valued procedure (and additional procedures) contingent upon application of other eligible reimbursement modifiers.

Add-on codes (procedures) are excluded from discounting. The concept may not be applicable as per the Provider Agreement when services are reimbursed at a percentage of billed charges or are otherwise exempt.

-52: Reduced Service – May require operative report review. Modifier -52 identifies that the service or procedure has been partially reduced or eliminated at the physician's discretion. The basic service described by the procedure code has been performed, but not all aspects of the service have been performed. When modifier -52 is used to indicate reduced services, the billing office should indicate what was different about the procedure (how was the service reduced) and approximately what percentage of the usual work was completed and/or not done. Claims for reduced services are manually priced. The allowance is adjusted based on the percentage of the full service that has been

performed and documented. When modifier 52 is submitted, the claim should be accompanied by a statement explaining what percentage and portion of the service was not completed and the operative report or records documenting the details of the service. Claims that are submitted without this documentation will be denied.

-53: Discontinued Procedure – Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure due to extenuating circumstances or those that threaten the well-being of the patient. When billing modifier 53 the provider should submit the length/amount of the procedure that was completed and the reason for discontinuing the service as documented within the operative report. A copy of the operative report is required. Reimbursement is based on the provider's allowable fee per percentage of service completed.

-54: Surgical Care Only – May require operative report review. When a physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding this modifier to the usual procedure code. Reimbursement will be 70% of the usual allowable.

-55: Postoperative Management Only – Use this modifier to indicate that payment for the postoperative, post-discharge care is split between two or more physicians where the physicians agree on the transfer of postoperative care. When transfer of care occurs immediately after surgery, the physician other than the surgeon who provides the in-hospital postoperative care submits the claim using subsequent hospital care codes for the inpatient hospital care and the surgical code with CPT modifier 55 for the post-discharge care. Reimbursement will be 20% of the usual allowable.

-56: Preoperative Management Only – This modifier is used by a physician or other qualified health care professional who performs preoperative care but does not provide the intraoperative (surgical) or postoperative services. This modifier is appended to the surgical procedure code. Reimbursement will be 10% of the usual allowable.

-57: Decision for Surgery – Informational only. Applies to an Evaluation and Management (E/M) service which a decision for surgery has been made by the physician. Modifier -57 is reserved for E/M's that result in major procedures (surgical or otherwise). Modifier -57 should be appended to any E/M service on the day of or the day before the procedure when the E/M service results in the decision to go to surgery.

-58: Staged or Related Procedure or Service by the Same Physician During the Postoperative Period – Informational only. It may be necessary to indicate that the performance of a procedure or service during the postoperative period of a first procedure was planned or anticipated (staged), more extensive than the original procedure, or for therapy following a surgical procedure. These circumstances may be reported by appending modifier -58 to the staged or related procedure. Modifier 58 breaks a global period and starts a new one. Use of modifier 58 will result in full payment, as the subsequent procedure is planned or staged or is more extensive than the initial procedure. Reimbursement will be 100% of the allowable fee. An operative report may be required.

-59: Distinct Procedural Service – Submitting modifier 59 with a procedure indicates that a distinct procedural service was performed, separate from other services rendered on the same day by the same provider. Modifier 59 should only be used when no other valid

modifier (e.g., site-specific) applies. For use of modifier 59, the medical record must clearly indicate the circumstances for reporting in this manner. Office/clinical notes may be requested. Modifier 59 should not be appended to an E/M service.

-62: Two Surgeons – May require operative report for physician review. This modifier is appended when the individual skills of two surgeons (each in a different specialty) are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition and the additional physician is not acting as an assistant at surgery (but instead a "co-surgeon"). If the two surgeons are required to perform a specific procedure, each surgeon bills for the procedure with modifier 62. Each surgeon will be paid 62.5% of their contracted rate so that in total 125% of the usual rate is paid.

-63: Procedure Performed on Infants less than 4 kgs. For eligible services or procedures reported with modifier 63 reimbursement will be 120% of the provider's usual allowable. Ineligible codes reported with modifier 63 will be denied.

-66: Surgical Team – May require operative report for physician review. Sufficient documentation must support that a team was medically necessary for a single, highly complex surgery or procedure. Each surgeon bills with modifier 66 appended. The team must include more than two surgeons of different specialties.

- When an eligible procedure is reported with team surgery modifier 66, the total reimbursement for the team of surgeons will be 150% of the applicable fee schedule rate for the procedure code. The total team surgery will be divided equally among the team of surgeons:
- For team surgery with three surgeons, each surgeon will be reimbursed 50% of the fee schedule amount.
- For team surgery with four surgeons, each surgeon will be reimbursed 37.5% of the fee schedule amount.
- No additional assistant surgeon claims will be allowed for the procedure codes reported with team surgery modifier 66.

If there is more than one procedure performed, multiple procedure reduction rules apply.

-73: Discontinued planned ambulatory surgery center (ASC) or outpatient hospital procedure prior to anesthesia administration –May require operative report for review. Procedures appended with modifier 73 are eligible for reimbursement when a planned procedure is discontinued due to medical complications threatening patient safety or wellbeing such as in the case of an allergic reaction to a medication. When modifier 73 is billed appropriately reimbursement is issued at 50% of the contractual allowable. Note: The elective cancellation of a procedure should not be reported such as when the patient does not show up or is non-compliant or changes their mind about having the procedure or the facility needs to re-schedule.

-74: Discontinue outpatient procedure after anesthesia administration – May require operative report/anesthesia report for review. Modifier 74 represents discontinued outpatient hospital/ambulatory surgery center (ASC) procedures after the administration of anesthesia. Due to extenuating circumstances or those that threaten the wellbeing of the patient the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s)/general anesthesia) or after the

procedure was started (an incision was made, or intubation started but terminated) can be reported by its usual procedure number and the addition of modifier 74. An operative report should be available upon request for facility claims billed with modifier 74 and include the following:

- Reason for termination of the surgery
- Description of the services performed.
- Description of the supplies provided.
- Services not performed that would have been if the surgery had not been terminated.
- Supplies that would have been provided if the surgery had not been terminated.
- Time spent in each stage (for example, pre-op, operative, and post-op)
- Time that would have been spent in each of the stages if the surgery had not been terminated.

Reimbursement will be 100% of the Provider Agreement allowable for the completed portion of the service.

-76: Repeat Procedure by Same Physician – Informational. Used when a physician needs to indicate that a service was repeated the same day subsequent to the original service. This modifier indicates the difference between duplicate services and repeated services.

-77: Repeat Procedure by Another Physician – Informational. Used when a different physician needs to indicate that a service was repeated the same day subsequent to the original service. This modifier indicates the difference between duplicate services and repeated services.

-78: Return to the Operating Room for a Related Procedure During the Postoperative Period. Modifier 78 is appended when it is necessary to indicate that another unplanned procedure was performed during the postoperative period of the initial period and the subsequent procedure is done because of a complication from the initial procedure. Use of Modifier 78 results in a payment reduction. Reimbursement will be 70-80% of the allowable fee. This reduction reimburses for the intra-operative portion of the procedure only since the patient's pre- and post-operative services are paid under the original surgery's fee. An operative report may be required.

-79: Unrelated Procedure or Service by the Same Physician During the Postoperative Period – Informational. Modifier 79 is used to indicate that the service is an unrelated procedure that was performed by the same physician during a post-operative period. Modifier 79 should be reported in the first position. A new post-operative period begins when the unrelated procedure is billed. An operative report may be required.

-80: Assistant Surgeon – Allowed only when a surgical assistant assists for the entire surgical procedure. Medical records (may be requested) must support the attendance of the assistant from the beginning of the surgery until the end of the procedure.

-81: Minimum Assistant Surgeon – Allowed only when a surgical assistant is present for a part of the surgical procedure.

-82: Assistant Surgeon – When a qualified resident surgeon is not available. Allowed only when a surgical assistant assists for the entire surgical procedure. Medical records

(may be requested) must support the attendance of the assistant from the beginning of the surgery until the end of the procedure.

-AS: Modifier AS is billed to indicate that a PA, NP or CNS served as the assistant at surgery.

Provider types eligible for reimbursement for Assistant at Surgery Services include:

- MD (Medical Doctor)
- DO (Doctor of Osteopathic Medicine
- PA (Physician's Assistant)
- NP (Nurse Practitioner)

Reimbursement – Assistant Surgeon Fee Adjustments

- Services reported by physician provider with modifier -80, -81 or -82 appended will be reimbursed at 20% of the established fee for the primary surgery less other pricing adjustments as applicable.
- Services reported by a non-physician provider with modifier -AS appended will be reimbursed at 80% of the 20% of the established fee for the primary surgery less other pricing adjustments as applicable.

Other pricing adjustments may also apply before the final allowed amount for each line item is determined include multiple surgery fee reductions and bilateral service adjustments.

Procedure codes with a CMS assistant surgeon indicator of "2" are eligible for assistant surgeon reimbursement. Ony one assistant surgeon is allowed per procedure code/surgery. A second assistant surgeon will be considered only when documentation of medical necessity is provided. Procedure codes with a CMS assistant surgeon indicator of "0" are not eligible for assistant surgeon reimbursement upon initial adjudication of the claim. However, an assistant surgeon may be allowed if documentation of medical necessity supports it. Per CMS guidelines, these procedures do not require an assistant surgeon, but an assistant surgeon may be medically necessary in some instances. Procedure codes with a CMS assistant surgeon indicator of "1" or "9" are not eligible for assistant surgeon reimbursement therefore reimbursement will not be issued when such services are billed with assistant at surgery modifiers appended.

-90: Reference (outside) Laboratory – Informational. Sometimes a clinical diagnostic independent laboratory billed with place of service code 81 refers a specimen to another laboratory for testing where a modifier 90 is appended. Independent laboratories are required to use modifier 90 to identify all referred laboratory services. Also report the name and CLIA number for the reference lab. A claim for a referred laboratory service that does not contain modifier 90 will be denied if the claim can otherwise be identified as being for a referred service.

-91: Repeat Clinical Diagnostic Laboratory Test – Informational. Modifier 91 is used to differentiate a repeat clinical diagnostic laboratory test when subsequent lab tests are performed on the same patient on the same day in order to obtain new test data over the course of treatment for the patient.

-93: Modifier 93 – Synchronous telemedicine services rendered via telephone or other real-time interactive audio-only telecommunications system. Required to identify audio-only services covered by VCHCP.

Ambulance Service Modifiers

For ambulance service, one-digit modifiers are combined to form a two-digit modifier that identifies the ambulance's place of origin with the first digit, and ambulance's destination with the second digit.

One-digit modifiers:

-D: Diagnostic or therapeutic site other than -P or – H when these are used as origin codes

-E: Residential, domiciliary, custodial facility (other than an 1819 facility)

-G: Hospital-based dialysis facility (hospital or hospital related)

-H: Hospital

-I: Site of transfer (for example, airport or helicopter pad) between types of ambulance

-J: Non-hospital-based dialysis facility

-N: Skilled nursing facility (SNF)

-P: Physician's office

-R: Residence

-S: Scene of accident or acute event

DME Modifiers:

-NR: New when rented. Use the NR modifier when the DME which was new at the time of rental is subsequently purchased. Usage of this modifier is appropriate when billing DME as a purchase item after it has been rented. Plan approval is required for "convert to purchase" DME.

-NU: New equipment – Modifier use may reflect purchase or convert to purchase DME. Prior authorization is required for rental DME.

-RA: Replacement of a DME, orthotic or prosthetic item (use RA modifier when DME is being replaced). Prior authorization is required for replacement DME.

-RB: Replacement of a part of a DME, orthotic or prosthetic item furnished as part of a repair.

-RR: Rental (use RR modifier when DME is being rented). Rental reimbursement applies when billed. Prior authorization is required for rental DME.

Other Commonly Billed HCPCS Modifiers:

-AS: Physician assistant, nurse, practitioner, or clinical nurse specialist services for assistant at surgery.

-E1: Upper left, eyelid

-E2: Lower left, eyelid

-E3: Upper right, eyelid

-E4: Lower right, eyelid

-F1: Left hand, second digit

-F2: Left hand, third digit

-F3: Left hand, fourth digit

-F4: Left hand, fifth digit

-F5: Right hand, thumb

-F6: Right hand, second digit

-F7: Right hand, third digit

-F8: Right hand fourth digit

-F9: Right hand, fifth digit

-FA: Left hand, thumb

-LT: Left side (used to identify procedures performed on the left side of the body)

-RT: Right side (use to identify procedures performed on the right side of the bode)

-SG: Ambulatory surgical center (ASC) facility service

-T1: Left foot, second digit

-T2: Left foot, third digit

-T3: Left foot, fourth digit

-T4: Left foot, fifth digit

-T5: Right foot, great toe

-T6: Right foot, second digit

-T7: Right foot, third digit

-T8: Right foot, fourth digit

-T9: Right foot, fifth digit

-TA: Left foot, great toe

-TC: Technical component – Reimbursement based on fee schedule for technical component only.

UB-04 Billing Guidelines and Requirements:

The UB-04 uniform billing form is the standard claim form that any institutional provider case use for the billing of medical claim. This includes:

- Comprehensive outpatient rehabilitation facilities
- Critical access hospitals
- End-stage renal disease facilities

- Home health agencies
- Hospices
- Hospitals
- Skilled nursing facilities

Tips for Preparing the UB-04 Form

To fill out the form accurately and completely, be sure to:

- Ensure that all data is entered correctly and accurately in the correct fields.
- Enter insurance information including the patient's name exactly as it appears on the insurance card.
- Use correct diagnosis codes (ICD-10) and procedure codes (CPT/HCPCS) using modifiers when required.
- Use only the physical address for the service facility location field.
- Include National Provider Identifier (NPI) information where indicated.

More detailed instructions can be found at www.cms.gov or www.nubc.org.

Requirements for UB-04 claim processing

Use the following guide to complete the UB04 (CMS-1450) claim form. See the reference table provided below this section for codes relative to the claim form field locators.

UB04 (CMS-1450) Claim Form Submission Guide

Failure to provide valid information matching the member's VCHCP ID card could result in the rejection of the claim. Incomplete or invalid billing information may cause a delay in processing or denial of the entire claim submission of a portion thereof.

Field	Field Description	Field Type	Billing Instructions
1	Facility name, Address and and Telephone Number	Required	This field contains the service address and telephone number and/or fax number. For contracted providers this information should match what is listed in your contract/Provider Services Agreement.
2	Pay-to Name and Address	Required	This field contains the address (if different field 1) to which payment should be sent. This information should match what is listed in your contract/Provider Services

			Agreement.
3a	Patient Control Number	Required	Complete this field with the patient account number assigned by the provider for individual patient financial record identification. This number will be included on the remittance advice sent from VCHCP to the provider.
3b	Medical Record Number	Conditional	Report the patient's medical record number assigned by the provider. This information is used for claims processing.
4	Type of Bill	Required	This field is for reporting of type of Facility, type of care and the bill sequence. It must be a valid, three-digit combination with a zero (0) prefix.
5	Federal Tax ID Number	Required	This number must match what is listed on your contract/Provider Services Agreement.
6	Statement Covers Period	Required	This field is used to report the start and end dates of service for the period reflected on the claim in a MMDDYY format.
7	Reserved for Assignment	Not Required	Not used. Leave blank.
8a	Patient Identifier	Not Required	Not used. Leave blank.
8b	Patient Name	Required	This field is for entering the patient's last name, first name and middle initial.
9a	Patient Address	Required	This field is for entering the patient's city.
10	Patient Birth Date	Required	Enter the patient's complete date of birth in an eight-digit (MMDDCCYY) format).
11	Sex	Required	This field is used to identify the sex of the patient.
12	Admission Date/ Start of Care Date	Required Required	Enter the date that the care begins or is initiated. For inpatient care, it is the

			date of admission.
13	Admission Hour	Required	Enter hour of patient's admission. Use Military Standard Time in top of the hour times only.
14	Admission/Visit	Required	Enter the number code to indicate the necessity for admission to the hospital. 1 – Emergency, 2 – Elective
15	Source of Referral	Conditional	This field identifies the point or source for the admission or visit (e.g., 2 – Clinic or Physician's Office.
16	Discharge Hour	Conditional	This field is used for reporting the hour the patient is discharged from inpatient care only.
17	Patient Discharge	Required	This field is used for reporting the status of the patient upon discharge (e.g., 01 = Discharged to Home or Self-Care (Routine Discharge). Required for Inpatient and outpatient.
18-28	Condition Codes	Conditional	Used this field to report conditions that may affect the processing of the claim (e.g., 02- Condition is employment Related).
29	Accident State	Conditional	This field is for reporting the two-digit Abbreviation of a state in which an accident occurred (if applicable).
30	Reserved for Assignment	Not Required	Not used. Leave blank.
31-34	Occurrence Codes and Dates	Conditional	Enter the occurrence code and the date field associated with it to identify a significant event that affects processing (e.g., accident, employment related, etc.).
35-36	Occurrence Span Codes and Dates	Conditional	Report the begin and end dates of the significant event.
37	Reserved for Assignment	Not Required	Not used. Leave blank.
38	Payer Name and Address	Required	Enter the name and address of the payer

			responsible for the bill.
39-41	Value Codes and Amounts	Conditional	These fields contain codes and the related dollar amounts to identify monetary data.
42	Revenue Codes	Required	Enter a valid, four-digit revenue code (one per claim line). Use 0001 to Indicate the "total" (for total billed charges) after all revenue codes have been included.
43	Revenue Code Description	Required	Enter the standard description of the revenue code.
44	HCPCS/Accommodation Rates	Conditional	Rates can be entered for accommodation revenue codes on inpatient claims but are not required. HCPCS are required for outpatient claims. Include modifiers when applicable. When submitting National Drug Code (NDC) for pharmacy, enter in form locator 43, the two-digit qualifier "N4" immediately followed by the 11-digit NDC>
45	Service Date	Required	Enter the date the service was rendered using the six-digit (MMDDYY) format.
46	Services Units	Required	Used to report number of units used and the number of inpatient days.
47	Total Charges	Required	Report the total charges for each detail line for covered and non-covered care for the billing period.
48	Non-Covered Charges	Conditional	Enter non-covered charges when applicable. The total of non-covered charges on revenue code 0001 line must equal sum of non-covered charges from claim detail lines.
49	Reserved for Assignment	Not Required	Not used. Leave blank.
50a, b, c	Payer Name	Required	Enter the name of the primary payer on line A; and if applicable, the secondary

			payer on line B; third payer on line C.
51a, b, c	Health Plan ID	Not Required	This line is for entering the National Health Plan ID number of the insurance plan that covers the patient.
52a, b, c	Release of Information	Required	Enter the appropriate code denoting whether the provider has signed a statement on file from the patient or patient's legal representative to release information to the plan.
53a, b, c	Assignment of Benefits	Conditional	Used to indicate whether the provider has a signed form authorizing the third party insurer to pay the provider directly for the service rendered. Not used for VCHCP claim processing.
54a, b, c	Prior Payments	Conditional	Used to enter any prior payment amounts the facility has received toward payment of the bill as indicated in Field 50, lines a, b, c. Used for coordination of benefits.
55a, b, c	Estimated Amount Due	Not Required	Enter the estimated amount due from the payer indicated in Field 50, lines a, b, c.
56	National Provider Identifier	Required	This field is for reporting the unique provider identifier assigned to the provider.
57	Other Provider Identifier	Not Required	Not used. Leave blank.
58 a, b, c	Insured's Name (last, first, and middle initial)	Required	The name of the individual (subscriber) carries the benefit is reported in this field. Enter the last name, first name and middle initial.
59a, b, c	Patient's Relationship to Insured	Required	Enter the applicable code that indicates the relationship of the patient to the insured.
60a, b, c	Insured's Unique Identification	Required	Enter the unique 11-digit identification number assigned to the insured individual by the health plan (i.e.,

			00900xxxx01). This must match the Member ID Number on the member's VCHCP ID card.
61a, b, c	Group Name	Not Required	Not used. Leave blank.
62a b, c	Insurance Group Number	Not Required	Not used. Leave blank.
63a, b, c	Treatment Authorization	Conditional	Enter the authorization number assigned by the health plan if applicable, known. This indicates that treatment was authorized.
64a, b, c	Documentation Control Number	Conditional	When submitting a corrected or replacement of a prior claim use this field to enter the VCHCP claim record number.
65a, b, c	Employer Name (Insured's)	Not required	Not used. Leave blank.
66	Diagnosis and Procedure	Required	Enter a "0" to indicate ICD-10
67	Principal Diagnosis Code	Required	Enter the principal ICD-10 diagnosis.
67a-q	Other Diagnosis Codes	Conditional	Report all additional diagnosis codes that coexist with the primary diagnosis, develop after admission, or impact the treatment of the patient or the length of stay.
68	Reserved for Assignment	Not Required	Not used. Leave blank.
69	Admitting Diagnosis	Required	Enter the valid ICD-10 diagnosis code describes the diagnosis of the patient at time of admission.
70a-c	Patient reason for visit	Conditional	Enter ICD-10 diagnosis codes that describe the patient's reason for the outpatient visit.
71	Prospective Payment System (PPS) Code DRG	Conditional	Required only when the provider is contracted with the health plan to use DRG codes.
72	External Cause of Injury (ECI)	Conditional	Enter the appropriate ICD-10 diagnosis

			code to report external causes of Injuries, poisonings or adverse effects.
73	Reserved for Assignment	Not Required	Not used. Leave blank.
74	Principal Procedure/Date	Conditional	Required for inpatient claim processing.
74a-e	Other Procedure Codes and Dates	Conditional	Required for inpatient claim processing when applicable.
75	Reserved for Assignment	Not Required	Not used. Leave blank.
76	Attending Provider Names and Identifiers (NPI)	Required	Use this field to report the name and identifier (NPI) of the provider responsible for the care provided on the claim.
77	Operating Physician Name and Identifiers (NPI)	Conditional	Use this field to report the name and identification number (NPI) of the physician responsible for performing the surgical procedure.
78-79	Other Provider Names and Identifiers	Conditional	Use this field to report the name and the identification number (NPI) for other rendering providers.
80	Remarks	Conditional	Use this field to report additional Necessary to process the claim.
81a-d	Code-Code Field	Not Required	Taxonomy codes should be reported in these fields use a qualifier of B3. This data is recommended but not required.

Fields of the UB-04

Use this section as a guide for selecting codes for the UB-04. Field Locator (FL) identifies the specific area of the claim where the information is to be entered.

Type of Bill (FL-4)

Enter the four-digit code that identifies the specific type of bill and frequency of submission. The first digit is a leading zero.

2nd – Digit – Submitting Facility

1 = Hospital

2 = Skilled Nursing

3 = Home Health

4 = Christian Science (Hospital)

5 = Christian Science (Extended Care)

6 = Intermediate Care

7 = Clinic

8 = Special Facility (Use "2nd Digit – Special Facilities Only" below)

2nd Digit - Bill Classification (Except Clinics and Special Facilities)

1 = Inpatient (Including Medicare Part A)

2 = Inpatient (Medicare Part B Only)

3 = Outpatient

4 = Other

5 = Intermediate Care – Level I

6 = Intermediate Care – Level II

7 = Intermediate Care – Level III

8 = Swing Beds

2nd Digit – Clinics Only

1 = Rural Health

2 = Hospital Based or Independent Renal Dialysis Center

3 = Free Standing

4 = Outpatient Rehabilitation Facility (ORF)

5 = Comprehensive Outpatient Rehabilitation Facility (CORF)

9 = Other

2nd digit – Special Facilities Only

1 = Hospice (Non-Hospital Based)

2 = Hospice (Hospital Based)

3 = Ambulatory Surgery Center

4 = Free Standing Birthing Center

9 = Other

3rd Digit – Frequency

0 = Non-payment/Zero Claim

1 = Admit Through Discharge Date (one claim covers entire stay)

2 = First Interim Claim

3 = Continuing Interim Claim

4 = Last Interim Claim

5 = Late Charge(s)

7 = Replacement of Prior Claim

Admission Hour (FL – 13)

Enter the hour (using a two-digit code below) that the patient entered the facility.

1:00 a.m. -01	2:00 a.m. -02
3:00 a.m. -03	4:00 a.m. -04
5:00 a.m. -05	6:00 a.m. -06
7:00 a.m. -07	8:00 a.m. -08
9:00 a.m. -09	10:00 a.m. -10
11:00 a.m. -11	12:00 noon -12
1:00 p.m. -13	2:00 p.m. -14
3:00 p.m. -15	4:00 p.m. -16
5:00 p.m. -17	6:00 p.m. -18
7:00 p.m. -19	8:00 p.m. -20
9:00 p.m. -21	10:00 p.m. -22
11:00 p.m. -23	12:00 a.m. -24/00

Admit Type (FL – 14)

Enter one of the following primary reasons for admission codes:

1 = Emergency

2 = Urgent

3 = Elective

4 = Newborn

5 = Trauma

9 = Information Not Available

Source of Admission (FL – 15)

Enter one of the following source of admission codes:

1 = Physician Referral

2 = Clinic Referral

3 = HMO Referral

4 = Transfer from Hospital

5 = Transfer from SNF

6 = Transfer from Another Health Care Facility

7 = Emergency Room

8 = Court/Law Enforcement

9 = Information Not Available

In the Case of Newborn

1 =Normal Delivery

2 = Premature Delivery

3 = Sick Baby

4 = Extramural Birth

Discharge Hour (FL – 16)

Enter the hour (using a two-digit code below) that the patient entered the facility.

1:00 a.m. -01	2:00 a.m. -02
3:00 a.m. -03	4:00 a.m. -04
5:00 a.m. -05	6:00 a.m. -06
7:00 a.m. -07	8:00 a.m. -08
9:00 a.m. -09	10:00 a.m. -10
11:00 a.m. -11	12:00 noon -12
1:00 p.m. -13	2:00 p.m. -14
3:00 p.m. -15	4:00 p.m. -16
5:00 p.m. -17	6:00 p.m. -18
7:00 p.m. -19	8:00 p.m. -20
9:00 p.m. -21	10:00 p.m. -22
11:00 p.m. -23	12:00 a.m. -24/00

Patient Discharge Status (FL -17)

Enter one of the following two-digit codes for the patient's status (as of the "through" date):

01 = Discharged to home or self-care (routine discharge)

02 = Discharged/transferred to another short-term general hospital

03 = Discharged/transferred to skilled nursing facility (SNF)

04 = Discharged/transferred to an intermediate care facility (ICF)

05 = Discharged/transferred to another type of institution

06 = Discharged/transferred to home under care of organized home health service organization

07 = Left against medical advice

08 = Reserved

09 = Admitted as an in-patient to this hospital (Medicare Outpatient Only)

20 = Expired (used only when the patient dies)

21 = Discharged or transferred to court/law enforcement; includes transfers to incarceration facilities such as jail, prison, or other detention facilities

22-29 = Reserved

30 = Still a patient or expected to return for outpatient services

31-39 = Reserved

40 = Expired at home (hospice claims only)

41 = Expired in a medical facility (hospital, SNF, ICF, or free-standing hospice)

42 = Expired – place unknown (Medicare Hospice Care Only)

43 = Discharged to Federal Health Care Facility (VA hospitals, VA Psych or VA nursing facilities)

50 = Hospice – Home

51 = Hospice – Medical Facility

52-60 = Reserved

61 = Discharged to Hospital Based Swing Bed

62 = Discharged to Inpatient Rehab

63 = Discharged to Long Term Care Hospital

64 = Discharged to Nursing Facility

65 = Discharged to Psychiatric Hospital

66 = Discharged to Critical Access Hospital

67-68 = Reserved

69 = Discharged/transferred to a designated disaster alternative care site

70 = Discharged/transferred to another type of health care institution (not defined elsewhere)

81 = Discharged to home or self-care with a planned acute care hospital inpatient readmission

82 = Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission

83 = Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission

84 = Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient admission

85 = Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission

86 = Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission

87 = Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission

88 = Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission

89 = Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission

90 = Discharged/transferred to an inpatient rehabilitation (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission

91 = Discharged/transferred to a Medicare Certified long term care hospital (LTCH) with a planned acute hospital inpatient readmission

92 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission

93 = Discharged/transferred to a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission

94 = Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission

95 = Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission

Condition Codes (FL 18-28)

Enter two-digit alpha numeric codes up to eleven occurrences to identify conditions that may affect processing of this claim. See National Uniform Billing Committee for guidelines.

Occurrence Codes and Dates (FL 31-34)

Enter up to four code(s) and associated date(s) for any significant event(s) that may affect processing of the claim.

01 = Auto Accident

02 = Auto Accident – No Fault Insurance

03 = Accident – Tort Liability

04 = Accident – Employment Related

05 = Other Accident

06 = Crime Victim

09 = Start of Infertility Treatment

11 = Illness – Onset of Symptoms

12 = Date of Onset for Chronically Dependent

16 = Date of Last Therapy

17 = Date of Outpatient Occupational Therapy

18 = Date of Retirement

20 = Date Guarantee of Payment Began

21 = Date UR Notice Received

22 = Date Active Care Ended

24 = Date Insurance Denied

25 = Date Benefits Terminated by Primary Payer

26 = Date Skilled Nursing Facility (SNF) Became Available

27 = Date Hospice Certification

28 = Date Comprehensive Outpatient Rehab

29 = Date Outpatient Physical Therapy

30 = Date Outpatient Speech Pathology

31 = Date Beneficiary Notified of Intent to Bill (procedures)

32 = Date Beneficiary Notified of Intent to Bill

33 = First Day of COB for ESRD

34 = Date of Election for Extended Care

35 = Date Treatment for Physical Therapy

36 = Date of Inpatient Discharge for Covered Transplant

37 = Date of Inpatient for Non-Covered Transplant

38 = Date Treatment for Home IV

39 = Date Discharged on Continuous IV

40 = Scheduled Date of Admission

41 = Date of First Test Pre-Admit

42 = Date of Discharge

43 = Cancelled Surgery

44 = Date Treatment Started Occupational Therapy

45 = Date Treatment Started Speech Therapy

46 = Date Treatment Started Cardiac Rehab

47 = Date Cost Outlier Begins

A1 – Birth Date – Insured A

A2 – Effective Date – Insured A Policy

A3 = Benefits Exhausted

A4 = Split Bill Date

B1 = Birth date – Insured B

B2 = Effective Date Policy B

B3 = Benefits Exhausted – Payer B

C1 = Birth Date – Insured C

C2 = Effective Date – Insured C

C3 = Benefits Exhausted – Payer C

Occurrence Span (FL 35-36)

Enter the span of occurrence dates as indicated in FL 31-35.

Value Code and Amount (FL 39-41)

Enter up to three value codes to identify special circumstances that may affect processing of this claim. See NUBC manual for specific codes. In the Amount box, enter the number, amount, or UCR value associated with that code.

Revenue Codes (FL 42)

Enter a four-digit Revenue Code beside each service described in column 43. (Commonly billed examples provided below). After the last Revenue Code, enter "0001" corresponding with the Total Charges amount in column 47. (Paper Claims Only)

0121 – MED-SUR-GY/SEMI (medical/surgical bed)

0122 – OB/SEMI PVT (obstetric bed)

0123 – PEDS/SEMI PVT (pediatric bed)

0127 – ONCOLOGY/SEMI (oncology bed)

0128 – REHAB/SEMI-PVT (rehabilitation bed)

0170 – NURSERY (boarder baby)

0171 – NURSERY/LEVEL I

0172 – NURSERY/LEVEL II (NICU, level two)

0173 – NURSERY/LEVEL III (NICU, level three)

0174 – NURSERY/LEVEL IV (NICU, level four)

0200 – INTENSIVE CARE

0203 – ICU/PEDS (Intensive Care Unit, pediatric bed)

0206 – INTERMEDIATE ICU

0208 – ICU/TRAUMA (Intensive Care Unit, trauma bed)

0210 – CORONARY CARE (CCU)

0214 – INTERMEDIATE CCU

0250 – PHARMACY (do not bill HCPCS code)

0258 – IV SOLUTIONS

0259 – DRUGS/OTHER

0260 – IV THERAPY

0270 – MED-SUR SUPPLIES
0271 – NON-STER SUPPLIES
0272 – STERILE SUPPLY
0274 – PROSTH/ORTH DEVICES
0275 – PACEMAKER
0276 – INTRA OCULAR LENS
0278 – SUPPLY/IMPLANTS (requires HCPCS code for processing outpatient services)
0300 – LAB
0301 – CHEMISTRY TESTS
0302 – IMMUNOLOGY TESTS
0305 – HEMATOLOGY TESTS
0306 – BACT & MICRO TESTS
0307 – UROLOGY TESTS
0309 – OTHER LAB TESTS
0310 – PATHOLOGY LAB
0311 – CYTOLOGY TESTS
0312 - HISTOLOGY
0320 – DX X-RAY
0321 – ANGIOCARDIOGRAPHY
0322 – ARTHROGRAPHY
0323 - ARTERIOGRAPHY
0324 – DX X-RAY/CHEST
0331 – RAD-CHEMO-INJECT
0332 – RAD-CHEMO-ORAL
0333 – RAD-RADIATION
0335 – RAD-CHEMO-IV
0340 – NUCLEAR MEDICINE
0341 – NUC MED/DX
0343 – NUC MED/DX RADIOPHARM
0350 – CT SCAN
0351 – CT SCAN/HEAD
0352 – CT SCAN/BODY
0360 – OR/GENERAL

0361 – MINOR SURGERY
0370 – ANESTHESIA
0371 – ANESTH/INCIDENT RAD
0401 – DIAG MAMMOGRAPHY
0402 – ULTRASOUND
0403 – SCRN MAMMOGRAPHY
0410 – RESPIRATORY SVC
0412 – INHALATION SVC
0421 – PHYS THERP/VISIT
0424 – PHYS THERP/EVAL
0431 – OCCUP THERP/VISIT
0434 – OCCUP THERP/EVAL
0441 – SPEECH THERP/VISIT
0444 – SPEECH THERP/EVAL
0450 – EMERG ROOM
0456 – URGENT CARE
0460 – PULMONARY FUNC
0471 – AUDIOLOGY/DX
0480 – CARDIOLOGY (GENERAL)
0481 – CARDIAC CATH LAB
0482 – STRESS TEST
0483 – ECHOCARDIOLOGY
0510 – CLINIC
0551 – SKILLED NURS-VISIT
0561 – HOME HEALTH MEDICAL SOCIAL SERVICES VISIT
0571 – HOME HEALTH AIDE VISIT
0611 – MRI/BRAIN
0612 – MRI/SPINE
0614 – MRI/OTHER
0615 – MRA/HEAD & NECK
0616 – MRA/LOWER EXTRM
0623 – SURGICAL DRESSINGS
0636 – DRUGS/DETAIL CODE (requires HCPCS code for outpatient services)

0651 – HOSPICE, ROUTINE HOME CARE

0652 – HOSPICE, CONTINUOUS HOME CARE

0655 – HOSPICE, INPATIENT RESPITE CARE

0656 – HOSPICE, GENERAL INPATIENT CARE

0710 – RECOVERY ROOM

0720 – DELIVERY ROOM/LABOR

0721 – LABOR

0722 – DELIVERY ROOM

0730 – EKG/ECG

0740 – EEG

0750 – GASTRO-INTSTL SVCS

0761 – TREATMENT RM

0762 – OBSERVATION HRS

0790 – EXTRA-CORPOREAL SHOCK WAVE THERAPY

0800 – RENAL DIALYSIS

0841 – CAPD/COMPOSITE

0851 – CCPD/COMPOSITE

0921 – PERI VASCUL LAB

0943 – CARDIAC REHAB

0948 – PULMONARY REHAB

When billing revenue codes, always include the CPT or HCPCS code as required. If a claim is missing a CPT or HCPCS code or includes an invalid match between CPT or HCPCS code and revenue code, it will be denied. Use revenue codes that are specific to body site or service type, if available. For example, when billing the service of Magnetic Resonance Imaging (MRT) of the brain, use the revenue code specific to the brain/brain stem. Do not bill a General or Other MRT revenue code to report this service, the claim will be denied. Only use a General or Other MRT revenue code for billing if the body site or service type specific to the procedure is not available for revenue code selection.

Revenue Code Description (FL 43)

Enter a brief description that corresponds to the Revenue Code in column 42. List applicable NDC if location 44 is a J code. Report the N4 qualifier in the first two positions, left justified, followed immediately by the 11-character NDC number.

Patient's Relationship to Insured (FL 59)

Enter the code for the patient's relationship to the insured.

01 = Spouse

18 = Self

19 = Child

20 = Employee

21 = Unknown

39 = Organ donor

53 = Life Partner

G8 = Other Relationship

CMS-1500 Billing Guidelines and Requirements:

Tips for Preparing the CMS-1500 Form

To fill out the form accurately and completely:

- Ensure that all data is entered correctly and accurately in the correct fields.
- Enter insurance information including the patient's name exactly as it appears on the insurance card.
- Use correct diagnosis codes (ICD-10) and procedure codes (CPT/HCPCS) using modifiers when required.
- Use only the physical address for the service facility location field.
- Include National Provider Identifier (NPI) information where indicated.

The National Uniform Billing Committee (NUCC) maintains the HCFA-1500 claim form and a set of data element specifications for professional claims submission via the HCFA-1500 claim form. The instruction manual is available at NUCC's website, www.nucc.org.

Fields of the CMS-1500

Use this section as a guide for selecting codes for the CMS-1500. Field Number identifies the specific area of the claim where the information is to be entered. Failure to provide valid information matching the member's VCHCP ID card could result in rejection of the claim. Incomplete or invalid billing information may cause a delay in processing or denial of the entire claim or a portion thereof.

Field#	Field Description	Field Type	Billing Instructions
1	Coverage	Optional	Check the appropriate box to indicate the type of health insurance coverage.
1a	Member's (Patient's) ID Number	Required	Enter the Member's identification (ID) number. This number must match the Member ID Number on the VCHCP ID card.
2	Member's (Patient's) Name	Required	Enter the member's last name, first name, and middle initial, if any. If there is a last name suffix or numerals (e.g., Jr or III) enter it after the last name. Do not use any punctuation. This

			data must match the Member Information contained on the VCHCP ID card.
3	Member's Birth Date and Gender	Required	Enter the member's birth date and sex. Use the eight-digit (MMDDCCYY) format for date of birth. Enter an X in the appropriate box to indicate the member's sex. Only one box can be selected.
4	Insured's (Subscriber's) Name	Required	Enter the insured's (subscriber's) last name, first name, and middle initial, if any. If there is a last name suffix or numerals (e.g., Jr or III) enter it after the last name. Do not use any punctuation.
5	Member's Address City, State, Zip Code and Telephone number	Required	Enter the member's mailing address and telephone number. On the first line, enter the street address; the second line, the city and state; the third line, the ZIP code and phone number. Do not use punctuation in the address. For the nine-digit ZIP code include the hyphen. Do not use hyphens or spaces within the telephone number.
6	Member's relationship to the insured	Required	Check the appropriate box for the member's relationship to the insured when item 4 is completed.
7	Insured's (Subscriber's) Address, City, state, ZIP code and telephone number	Required	Enter the Insured's (Subscriber's) address or "same" if it is not different from the patient's address. Do not use punctuation. When entering nine-digit ZIP code; include the hyphen. Do not use a hyphen or space as a separator within the telephone number.
8	Reserved for Assignment	Not Required	Not used. Leave blank.
9	Other Insured's Name	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimburse-ment of the claim. Enter the name (last name, first name, middle initial) of the person who is insured under another payer.

9a	Other insured's Policy or group Number	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with reimbursement of the claim. Enter the policy information of of the other payer.
9b	Reserved for Assignment	Not Required	Not used. Leave blank.
9c	Reserved for	Not Required	Not used. Leave blank.
9d	Other insured's insurance plan name or program name	Conditional	Enter if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's insurance company or name.
10a-c	Is the member's condition related to: -Employment? -Auto Accident? -Other Accident?	Required	Place an "X" in the corresponding box indicating whether or not the condition for which the member is being treated is related to current or previous employment, an automobile accident or any other accident. Enter an "X" in either the YES or NO box for each question.
10d	Claim Codes (Designated by NUCC)	Not Required	Not used. Leave blank.
11	Insured's Policy, Group or FECA Number	Not Required	Not used. Leave blank.
11a	Insured's Date of Birth and Sex	Required	Enter the insured's (subscriber's) Date of Birth. Enter in a MMDDYY format. Check the Appropriate box the for the insured's sex.
11b	Other Claim ID (Designated by NUCC)	Not Required	Not used. Leave blank.
11c	Insurance Plan Name Or Program Name	Required	Enter the insured's insurance company or program name.
11d	Is There Another Health Benefit Plan?	Required	Place an "X" in the box indicating whether there may be other insurance involved in the re-imbursement of the claim. If "yes" complete items 9, 9a, 9b and 9d.
12	Member's or	Required	The member must sign and date a form with the

	Authorized person's Signature		provider authorizing release of medical information to the health plan. The member's signature authorizes the release of medical record information (if necessary) to process the claim.
13	Insured's or Authorized person's Signature	Required	The insured's signature authorizes payment of benefits by the health plan to the provider. "Signature on file" (SOF) is acceptable.
14	Date of current illness, Injury or Pregnancy	Conditional	Enter the 6-digit (MM/DD/YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 = Onset of current symptoms or illness/484 = LMP.
15	Other Date	Conditional	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM/DD/YY) or 8-digit format (MM/DD/YYYY) format. 454 = Initial treatment, 304 = Latest visit or consultation, 453 = Acute manifestation of a chronic condition, 439 = Accident, 455 = Last **x**-ray, 471 = Prescription, 090 = Report Start (Assumed Care Date), 091 = Report End (Relinquished Care Date), 444 = First visit or consultation.
16	Dates member unable to work in current occupation.	Conditional	If the patient is employed and is unable to work in current occupation, a 6-digit (MM/DD/YY) or 8-digit date must be shown for the "from-to" dates that the patient is unable to work. An entry in this field my indicate employment-related insurance coverage.
17	Name of Referring Source/Qualifier	Conditional	Enter the Enter the applicable qualifier to identify which provider is being

			reported (DN = Referring provider, DK = ordering provider, DQ = Supervising provider. Enter the name of the referring physician or other source, if applicable.
17a	ID Number of Referring Physician/Qualifier	Conditional	The Other ID number of the referring, ordering, or supervising physician is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.
17b	National Provider Identifier (NPI)/ Qualifier	Conditional	Enter the NPI of the referring or ordering physician listed in item 17. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.
18	Hospitalization Dates Related to Current Services	Conditional	Required if the claim includes charges for services rendered during an inpatient admission. Enter dates in MMDDYY format.
19	Additional Claim Information (Designated by NUCC)	Conditional	Use this field to enter comments (additional information) related to the processing of the claim.
20	Outside Lab/Charges	Conditional	Enter if lab tests performed and billed on the claim was processed by a lab outside the provider's premises.
21(1-4)	Diagnosis or nature of illness or injury	Required	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 0 = ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand.
22	Resubmission Code/ Original Reference Number	Conditional	Use the original claim record (reference) number for resubmitted claim. When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field ("7" = replacement claim). Do not use this function to void or cancel a prior claim submission.
23	Prior Authorization Number	Conditional	Include the authorization record number applicable to the claim, if service requires prior

			authorization. Do not enter any comments in this field. Do not use this field to request retro-active authorization.
24a	Dates of Service	Required	Enter this information in a MMDDYY format to show the start "From" and end date "To" of care. Do not include dates for service scheduled in the future. These claims will be rejected.
24b	Place of Service	Required	Enter the appropriate place of service code to report the type of facility or location were the service(s) were rendered.
24c	EMG	Conditional	Enter a "Y" if the service provided was in response to an emergency. Otherwise, leave this item blank.
24d	Procedures, services or supplies	Required	Enter a valid CPT or HCPCS code for each service rendered.
24d	Modifier	Conditional	Enter a modifier when applicable for each service rendered (e.g., 25, 26, 50, 51). The CMS-1500 claim form allows up to four Modifiers.
24e	Diagnosis Pointer	Conditional	Enter the diagnosis code reference number ("1" or "2", etc.) as shown in item 21 to relate the service date and procedures to the diagnosis. Enter the applicable reference numbers per detail line (electronic claims allow up to four reference numbers per line). Do not enter the diagnosis code.
24f	Charges	Required	Enter the billed charge amount for each service.
24g	Days or Units	Required	Enter the number of units or days that correspond to the "From" and "To" dates indicated in Field 24a.
24h	EPSDT Family Planning	Not Required	Not Used. Leave blank.
24i	ID Qualifier	Conditional	Enter the provider's two-character qualifier ID (e.g., G2)

24j	Rendering Provider	Required	Enter the NPI number in the unshaded area in the field.
25	Federal Tax ID Number	Required	Enter the nine-digit Employee Identification Number (EIN) under which payment for services is made to.
26	Member's Account Number	Optional	Enter the unique account number assigned by the provider for the member. This number will be included in the reimbursement detail for the member on the provider's remittance advice.
27	Accept Assignment?	Conditional	Enter an "X" in the appropriate box. A check in "Yes" box indicates that the patient has signed paperwork to allow that benefits be paid to the provider.
28	Total Charge	Required	Enter the total charges for the detail entered on lines 24 (1-6) of the claim.
29	Amount Paid	Conditional	If there is another insurance involved with the reimbursement of the claim, enter the total amount paid by the other payer.
30	Reserved for Assignment	Not Required	Not used. Leave blank.
31	Signature of or Supplier	Required	Signature of Physician or Supplier including Degree(s) or Credentials and Date of Signature.
32	Name and Address of Facility Where Services Were Rendered	Required	Enter the name and address of the location where services were rendered.
32a	NPI	Conditional	Enter the NPI of the service facility. Only report a Service Facility Location NPI when the NPI is different from the Billing Provider NPI.
32b	Other ID#	Not required	Not used. Leave blank.
33	Physician's/Supplier's billing name, address, zip code and phone	Required	Enter the appropriate information.
33a	NPI	Required	Enter the NPI of the billing provider or group.
33b	Other ID#	Not required	Not used. Leave blank.

Place of Service Codes

Listed below are commonly billed place of service codes and descriptions. These codes are used on professional claims to specify the entity where service(s) were rendered.

Code	Place Name
11	Office
12	Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	On Campus – Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility
34	Hospice
41	Ambulance – Land
42	Ambulance – Air or Water
51	Inpatient Psychiatric Facility
61	Comprehensive Inpatient Rehabilitation Facility
65	ESRD Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory

Place of Service Code 50 is Invalid

VCHCP is a commercial insurance plan and does not accept place of service code 50 because it is applicable to Medicare beneficiaries. Claims submitted with place of service code 50 will be denied for *invalid place of service*.

50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.

Outpatient/Inpatient Consultations

The Plan does not accept consultation codes unless your provider contract specifically allows them to be billed. Physicians must use visit/outpatient or inpatient hospital evaluation and management codes to bill for consultation services. Listed below is a cross- walk of codes used for reporting consultations provided in an office or in an outpatient or other ambulatory facility, including hospital observation services, domiciliary, rest home or emergency department.

- Report 99202 instead of 99241 for new patients effective for service dates 1/01/2021. CPT code 99201 was deleted on 12/31/2020 because 99201 and 99202 have the same level of medical decision making (straightforward).
- Report 99211 instead of 99241 for established patients. (CPT code 99241 was deleted on 12/31/2022)
- Report 99202 instead of 99242 for new patients.
- Report 99212 instead of 99242 for established patients.
- Report 99203 instead of 99243 for new patients.
- Report 99213 instead of 99243 for established patients.
- Report 99204 instead of 99244 for new patients.
- Report 99214 instead of 99244 for established patients.
- Report 99205 instead of 99245 for new patients.
- Report 99215 instead of 99245 for new patients.
- Report 99221 instead of 99251 for acute hospital consultations.
- Report 99304 instead of 99251 for nursing home consultations.
- Report 99221 or 99222 instead of 99252 for acute hospital consultations.
- Report 99304 or 99305 instead of 99252 for nursing home consultations.
- Report 99222 instead of 99253 for acute hospital consultations.
- Report 99305 instead of 99253 for nursing home consultations.
- Report 99222 or 99223 instead of 99254 for acute hospital consultations.
- Report 99305 or 99306 instead of 99254 for nursing home consultations.
- Report 99223 instead of 99255 for acute hospital consultations.
- Report 99306 instead of 99255 for nursing home consultations.

Evaluation and Management (E/M) Codes – CPT® 2021 Guidelines

New CPT® guidelines for reporting Office and Other Outpatient E/M services were created, effective January 1, 2021, wherein E/M codes for office and outpatient services will be selected based on medical decision making (MDM) *or* time. Providers will no longer be required to document a certain level of history or exam to meet code criteria.

The provider will decide what levels of history and exam are required to treat the patient. Because 99201 and 99202 have the same level of MDM (straightforward), 99201 is deleted. The code descriptors for 99202-99215 are revised to include a "medically appropriate history and/or examination". The time designations were also revised for each code. For example, the descriptor for CPT code 99202 designates code selection for 15-29 minutes of total time spent on the date of the encounter. The 2021 CPT guidelines include multiple definitions for key terms to support the new MDM table that is included in the 2021 CPT code book. Time is redefined as total time instead of face-to-face time. The total time used for code selection includes the time spent by the provider on the date of service which encompasses:

- Preparing to see the patient
- Obtaining history and performing an exam
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other healthcare professionals
- Documenting in the health record; independently interpreting tests (not separately reported) and communicating results; and
- Care coordination (not separately reported).

These changes only apply to Office/Other Outpatient services (CPT codes 99202-99215). Use MDM *or* time to determine the correct code (both requirements do not need to be met).

Revisions to coding of Evaluation and Management (E/M) services effective January 1, 2023 include:

Inpatient and Observation Care Services

Observation care discharge (99217), initial observation care (99218, 99219, 99220), and subsequent observation care (99224, 99225, 99226) are deleted and merged into the existing hospital care CPT codes (99221-99223, 99231-99233). Hospital discharge (99238-99239) codes and guidelines are revised to include observation care services.

Initial hospital care (99221-99223), subsequent hospital care (99231-99233), observation or inpatient hospital care (99234-99236) codes and guidelines are revised to include observation care services. To report initial observation care, new or established patient, see 99221, 99222, 99223. To report subsequent observation care, see 99231, 99232, 99233). For a patient admitted and discharged from hospital inpatient or observation status on the same date, report 99234, 99235, 99236, as appropriate.

Observation Care Services

Outpatient observation stays: Hospitals may provide observation care if a patient is not well enough to go home but not sick enough to be admitted as inpatient. Observation care is a set of services that are provided while a patient's treatment and discharge are being decided. These services include assessment, reassessment, and ongoing short-term treatment. These stays require a physician's order and are considered outpatient services even though the patient may be observed in the hospital overnight up to twenty-four

hours. At Ventura County Medical Center, observation stays may be up to two (2) midnights. All other facilities, including tertiary observation stays are up to twenty-four (24) hours. At 24 hours and after, the patient's stay is considered an inpatient admission. For all facilities (contracted/non-contracted), prior authorization is not required for the following services:

- Emergency department services with observation (revenue codes 0450/0762)
- Observation services only (revenue code 0762)

The medical record must include documentation stating the stay for observation care involves at least 8 hours and less than 24 hours during the stay.

Professional Claims

Place of service code: Observation care is typically billed with place of service code 22 (outpatient hospital).

Codes: In calendar year 2023, observation care is billed by practitioners using the same CPT codes as hospital inpatient care (CPT code ranges 99221-99223, and 99231-99239). These codes replaced deleted hospital observation codes 99217-99220 and 99224-99226.

Billing Observation/Hospital Inpatient or Observation Care Services (Including Admission and Discharge Services)

If a patient is admitted to outpatient observation and discharged on the same calendar day, the observation admission including discharge codes may be applicable. Initial observation including discharge care on the same date of service may be billed using codes 99234-99236.

OB triage with observation services: Requires physician's order for observation. Refer to section Obstetric (OB) Triage for further guidance.

Consultations

Office consultation code 99241 and inpatient consultation code 99251 are deleted. CPT codes 99242-99245, 99252-99255 have been revised. CMS eliminated the use of all consultation CPT codes effective January 1, 2010. Contracted providers should not bill consultation codes unless allowed by your provider services agreement.

Emergency Department Services

There are no changes to the codes for emergency department visits (99281-99285), however the guidelines/service code descriptions have been revised.

Nursing Facility Services

Nursing facility assessment code 99318 is deleted and all other codes (99304-99310, 99315-99316) and guidelines under Nursing Facility Services are revised.

Home and Residence Services

The Domiciliary, Rest Home (e.g., Boarding Home) and Custodial Care Services subsection of CPT codes is deleted, along with new patient codes 99324-99328 and established patient codes 99334-99337. Domiciliary, Rest Home (e.g., Assisted Living Facility), or Home Care Plan Oversight Services guidelines are revised, and supervision codes 99339-99340 are deleted.

Reporting Prolonged Clinical Staff Time Using 99415, 99416

Codes 99415, 99416 are used when an E/M service is provided in the office or outpatient setting that involves prolonged clinical staff face-to-face time beyond the highest total time of the E/M service, as stated in the ranges of time in the code descriptions. This service is reported in addition to the designated E/M services and any other services provided at the same session as E/M services. Code 99415 is used to report on the first hour of prolonged clinical staff service on a given date. Code 99416 is used to report each additional 30 minutes of prolonged clinical staff service beyond the first hour. Code 99416 may also be used to report on the final 15-30 minutes of prolonged service on that date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately. Refer to the grid below for reporting guidance on CPT codes 99415, 99416:

CODE	Typical Clinical Staff Time	99415 Time Range (Minutes)	99416 Start Time (Minutes)
99202	29	59-103	104
99203	34	64-108	109
99204	41	71-115	116
99205	46	76-120	121
99211	16	46-90	91
99212	24	54-98	99
99213	27	57-101	102
99214	40	70-114	115
99215	45	75-119	120

Prolonged Services

Prolonged Service with Direct Patient Contact (Except with Office or Other Outpatient Services) codes 99354, 99355 have been deleted. For prolonged E/M services on the date of an outpatient service, home or residence service, or cognitive assessment and care plan, use 99417. *CPT code 99417* describes a 15-minute prolonged office or other E/M services (with OR without direct patient contact), done on the same day as

office/outpatient *codes* 99205 and 99215. Guidance for usage of 99417 is provided below.

CPT codes 99356, 99357 have been deleted. For prolonged E/M services on the date of an in-patient or observation or nursing facility service, use99418. Guidance for usage of 99418 is provided below.

Reporting Prolonged Time Using CPT code 99417with Codes 99205, 99215, 99245, 99345, 99350 and 99483.

To report a unit of 99417 15 minutes of time must have been attained. Do not report 99417 for any time increment of less than 15 minutes. When reporting 99417 the initial time unit of 15 minutes should be added once the time in the primary E/M code has been surpassed by 15 minutes. For example, to report the initial unit of 99417 for a new patient encounter (99205), do not report 99417 until at least 15 minutes of time has been accumulated beyond 60 minutes (i.e., 75 minutes) on the date of the encounter. For an established patient encounter (99215), do not report 99417 until at least 15 minutes of time has been accumulated beyond 40 minutes (i.e., 55 minutes) on the date of the encounter. Refer to the grid below for sample reporting guidance on CPT code 99417.

Billing CPT Codes 99205, 99215, 99245 with 99417 (Consultation codes are only billable when your contractual agreement allows it).

Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	**Codes(s)**
Less than 75 minutes	Not reported separately
75-89 minutes	99205 X 1 and 99417 X 1
90-104 minutes	99205 X 1 and 99417 X 2
105 minutes or more	99205 X 1 and 99417 X 3 or more for each additional 15 minutes
Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	**Code(s)**
Less than 55 minutes	Not reported separately
55-69 minutes	99215 X 1 and 99417 X 1
70-84 minutes	99215 X 1 and 99417 X 2
85 minutes or more	99215 X 1 and 99417 X 3 or more for each additional 15 minutes
Total Duration of Office or Other Outpatient Consultation Services (use with 99245)	**Code(s)**
Less than 70 minutes	Not reported separately
70-84 minutes	99245 X 1 and 99417 X 1
80-99 minutes	99245 X 1 and 99417 X 2
100 minutes or more	99245 X 1 and 99417 X 3 or more for each additional 15 minutes

Refer to the grids below for reporting CPT code 99418 for Hospital Inpatient, Observation Care Services or Nursing Facility Services. CPT code 99418 is used in conjunction with 99223, 99233, 99236, 99255, 99306 and 99310. However, it may not

be reported for any time unit less than 15 minutes. Consultation codes are only billable when your contractual agreement allows it.

Hospital Inpatient and Observation Care Services

Initial Hospital Inpatient or Observation Care, CPT code 99223, less than 90 minutes	Not reported separately
CPT code 99223, greater than 90 minutes	99223 X 1 and 99418 X 1
Subsequent Hospital Inpatient or Observation Care, CPT code 99233, less than 65 minutes	Not reported separately
CPT code 99233, greater than 65 minutes	99233 X 1 and 99418 X 1
Hospital Inpatient or Observation Care, CPT code 99236, less than 100 minutes	Not reported separately
CPT code 99236, greater than 100 minutes	99236 X 1 and 99418 X 1
Inpatient or Observation Consultation, CPT code 99255, less than 95 minutes	Not reported separately
CPT code 99255, greater than 95 minutes	99255 X 1 and 99418 X 1

Nursing Facility Services

Initial Nursing Facility Care, CPT code 99306, less than 60 minutes	Not reported separately
CPT code 99306, greater than 60 minutes	99306 X 1 and 99418 X 1
Subsequent Nursing Facility Care, CPT code 99310, less than 60 minutes	Not reported separately

Prolonged Service on Date Other Than the Face-to-Face Evaluation and Management Service (E/M) Without Direct Patient Contact.

Codes 99358 and 99359 are used when a prolonged service is provided on a date other than the date of a face-to-face E/M encounter with the patient and/or family/caregiver. Codes 99358, 99359 may be reported for prolonged services in relation to any E/M service on a date other than the face-to-face service whether or not time was used to select the level of the face-to-face service. This service is to be reported in relation to other physicians or other qualified health care professional services, including E/M services at any level, on a date other than the face-to-face service to which it is related. Codes 99358 and 99359 are used to report the total duration of non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service, even if the time spent by the physician or other qualified health care professional on that date is not continuous. Code 99358 is used to report the first hour of prolonged service on a given date regardless of the place of service. It should be used only once per date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported. Code 99359 is used to report each additional 30 minutes beyond the first hour. It may also be used to report the final 15 to 30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately. Do not report 99358, 99359 for time without direct patient contact reported in other services, such as care plan oversight services (codes 99374-99380), chronic care

management by a physician or other qualified health care professional (codes 99437, 99491), principal care management by a physician or other qualified health care professional (codes 99424, 99425, 99426, 99427), home and outpatient INR monitoring (codes 93792, 93793), medical team conferences (codes 99366-99368), interprofessional telephone/Internet/electronic health record consultations (codes 99446, 99447, 99448, 99449, 99451, 99452), or online digital E/M services (codes 99421, 99422, 99423). Use 99359 in conjunction with 99358. Do not report 99358, 99359 on the same date of service as 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99242, 99243, 99244, 99245, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99417, 99418, and 99483.

OTHER SERVICES AND GENERAL INFORMATION

Inpatient Billing

When billing for an inpatient hospital admission the "From Date" located in the Statement Covers Period field of the UB 04 claim form must reflect either the first date of all diagnostic testing services (e.g., radiology and laboratory) related to the admission rendered by the facility within 72 hours of the admission, the date the member was seen in the emergency department prior to admission, or the date of elective admission. The "Thru Date" located in the Statement Covers Period field of the UB 04 claim form must reflect the discharge date of the admission.

The admission date (field 12) of the UB 04 claim form must reflect the date the patient was admitted as an inpatient to the facility by the admitting physician.

Claims billed with incorrect dates will be denied. A corrected claim must be submitted. Inpatient claims will be reviewed for record of authorization as required. To process claims correctly, additional information, such as medical records or an itemized statement of charges, may be requested.

Immediate Postpartum Contraception

Effective January 1, 2025, VCHCP will cover immediate postpartum contraception which is defined as the *postpartum insertion of intrauterine devices or contraceptive implants performed before the member is discharged from a general acute hospital.* The Plan will authorize a health care provider to separately bill separately for devices, implants, professional services, or a combination thereof, associated with immediate postpartum contraception. Intrauterine devices and contraceptive implants will not be part of a payment for a general obstetric procedure. Such items will carve out and pay at the applicable exception rate defined within the provider's contract. The claim submitted by the general acute hospital will be reviewed to identify the contraceptive implant or intrauterine device using applicable UB04 Revenue Codes: 278 (implants) (or other qualifying revenue code) and the corresponding ICD-10-PCS code.

Professional services for insertion of immediate postpartum contraception will be paid at the provider's contracted rate. For example: Insertion of a non- biodegradable drug delivery implant (CPT code 11981) billed with place of service code 21 (inpatient).

For inpatient deliveries the hospital should submit a UB04 revenue code to identify the contraceptive implant or device along with a qualifying ICD-10-PCS procedure code such as those listed below.

ICD-10-PCS procedure codes can include

- Intrauterine device (IUD): **0UH9HZ** is the ICD-10-PCS for inserting an IUD into the uterus.
- Nexplanon implant: **OJHD3HZ** is the ICD-10-PCS for inserting a Nexplanon implant into the right upper arm, and **OJHF3HZ** is the code for the left upper arm.
- Contraceptive device into the left lower arm: **JHH3HZ** is the ICD-10-PCS code for inserting a contraceptive device into the left lower arm.

ICD-10-CM Diagnoses can include

- Z30.017 - Initial prescription, counseling/advice/insertion of an implantable subdermal contraceptive.
- Z30.430 – Encounter for insertion of intrauterine contraceptive device
- Z30.46 – Encounter for surveillance of implantable subdermal contraceptive. This code is reported for checking, reinsertion, or removal of the implant.

Preadmission and Preoperative Services: Three-day Window (72 hour) Rule for Inpatient Facility Claims

Diagnostic services such as clinical diagnostic laboratory tests, examinations radiology and EKGs provided to a member by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital within 3 days prior to and including the day of the member's admission are deemed to be inpatient services and included in the inpatient payment.

Revenue Codes – Institutional Claims

Revenue codes are 4-digit numbers as approved by the National Uniform Billing Committee (NUBC) that are billed on the CMS-1450, the institutional claim form. Revenue codes hold information about a patient's treatment or services performed by health care providers; they summarize charges for each cost center. Institutional providers who bill inpatient and outpatient services on the CMS-1450 include but are not limited to Hospitals, Skilled Nursing Facilities (SNFs), End-Stage Renal Disease Centers, Hospices and Home Health Agencies. Occupational, Physical and Speech therapy services can also be billed on the CMS-1450.

Guidelines for Billing Revenue Codes on Institutional Claims

- Field 42 of the CMS-1450 claim form is designated for revenue codes.
- Revenue codes are required to be submitted with 4 digits (e.g., 0250 – General Pharmacy)

- The claim's bill type must support the revenue codes billed. For example, bill type 0131-Outpatient hospital claim is incorrect when billed in combination with revenue code 0121-Inpatient semi-private medical/surgical bed. Claims billed with an invalid bill type and revenue code combination will be denied.
- Submit only valid HCPCS and revenue code combinations. Invalid combinations will be denied.
- Revenue codes requiring but missing a HCPCS code will be denied.
- Use the most specific revenue code available for the service type.

The Plan uses CMS guidelines and industry standards to determine accuracy of the revenue codes billed by providers; the General revenue code category for a service may be acceptable for some procedures in lieu of a more specific revenue code however, the Other category is almost never accepted. Services like magnetic resonance technology (MRT) require claims to contain a valid revenue code to CPT code match, such as when a provider bills a spinal MRT CPT code, revenue code 0612 is the valid match rather than General or Other. Denied claims require correction for reconsideration.

Hospice Services

Hospice care is support and care for persons in the last phase of an ostensibly uncurable disease process. It is essentially palliative care exclusive of curative or life-prolonging interventions. In general, life expectancy would be less than six months. Hospice care may be initiated as inpatient or outpatient (either home-bound or not home-bound).

Hospice services are billed on a CMS-1450 claim form. Applicable revenue codes include (this is not an all-inclusive list):

- 0650 (General)
- 0651 (Routine home care)
- 0652 (Continuous home care)
- 0655 (Inpatient respite care)
- 0656 (General inpatient care)
- 0657 (Physician services)

Hospice requires authorization but does not have a cost share. Physician services provided during hospice are generally uncommon but do require review for medical necessity when billed.

Preoperative Services for Outpatient Facility Surgical Claims

For outpatient facility claims, preoperative services performed at the same facility within 72 hours of the date of surgery are separately reimbursable when included on the surgical claims.

Outpatient Prospective Payment System (OPPS)

The Outpatient Prospective Payment System (OPPS) sets payments for procedures using a set of relative weights, a conversion factor (or base payment amount), and adjustments for geographic differences in input prices. All items and services paid under OPPS are assigned to payment groups called Ambulatory Payment Classifications (APCs), which group together items and services that are similar clinically and in terms of resource use.

Addendum B on the CMS website contains OPPS related information for the HCPCS codes including the APC categories, payment rates which update on a quarterly basis and Status Indicators (SI) assigned to each HCPCS code that provide additional information on payment instruction. For example, Status Indicator N signifies a service or items where "payment is packaged into payment for other services". This means there is no separate APC payment applicable.

Contracts that reimburse with OPPS rates generally follow Medicare guidelines for processing claims. Services excluded from payment under OPPS include, but are not limited to, clinical diagnostic laboratory services, outpatient therapy (physical, occupational and speech therapy) services, ambulance services, non-implantable prosthetic and orthotic devices, and screening and diagnostic mammography. OPPS Addendum D1 contains a complete list of the payment status indicators. If applicable, refer to your contractual agreement for rates and other information regarding OPPS payment.

Ambulatory Surgery Centers (ASC) Payment

Ambulatory Surgery Centers, known as ASCs, are outpatient free-standing health care facilities focused on providing same-day surgical care, including diagnostic and preventive procedures such as screening colonoscopy.

CMS publishes updates to the list of covered surgical procedures for which an ASC may be paid each year. In addition, CMS publishes quarterly updates to the lists of covered surgical procedures and covered ancillary services to establish payment indicators and payment rates for newly created Level II HCPCS and Category III CPT codes. The ASC procedure and payment amounts are grouped by the Core-Based Statistical Area (CBSA) code. For example, the CBSA code for Ventura County is 37100 which covers Oxnard, Thousand Oaks, and Ventura. ASC services have a separate indicator list that advises if the service is payable, subject to multiple procedure reductions and other information (see Addendum AA). Addendum DD1 contains the payment status indicator code and descriptions to help explain how a claim was processed. For example, Status Indicator N1 signifies a "Packaged service/item; no separate payment made". This means there is no separate APC payment applicable. For additional details view CMS' ASC Payment Rates Addenda. If applicable, refer to your contractual agreement for rates and other information regarding ASC payment.

Endovascular Surgery

Endovascular surgery is a procedure that is performed using minimally invasive catheter techniques on the arteries or veins. Procedures include aneurysm repair, grafts, stents, varicose vein repair, and more. Endovascular surgery is often performed on an outpatient basis including hospital settings and in ambulatory surgery centers. This service requires prior authorization. Cost sharing applies.

The CPT code manual provides billing and reimbursement guidelines for endovascular surgery-related services (e.g., selective catheterization and transversing the lesion, and radiological supervision and interpretation) which include describing if these services are inclusive to the primary service (or not). If deemed inclusive they are not separately reimbursed and will be denied for that reason. If not inclusive, payment will be issued in

accordance with the Provider Agreement and CPT reimbursement modifiers such as -50 (bilateral) and -51 (multiple procedure) if applicable to the procedure(s).

CPT Code examples (not an all-inclusive list) include:

- 34001-34203 (Arterial Embolectomy/Thrombectomy, with or without catheter)
- 34401-34490 (Venous Embolectomy/Thrombectomy, Direct or with catheter
- 34701-34834 (Endovascular repair procedures of the abdominal aorta and/or iliac arteries

Note: Unlisted procedures (i.e., 37799) require a description of the service on the claim form and medical necessity review. Medical records may be requested.

Gastrointestinal Services – GI Laboratory

Specialized gastrointestinal (GI) services performed in a GI laboratory should be billed with revenue code 0750 – Gastrointestinal Services; this includes services such as esophageal motility studies billed under CPT codes 91010 and 91013. No authorization is required when performed by a contracted provider except for tertiary care. The Gastroenterology range of services includes CPT codes 91010 – 91122 (these codes may not represent an all-inclusive list of services).

Cardiac Rehab

Cardiac rehab is a medically supervised program designed to improve cardiovascular health for members who have experienced heart attack, heart failure, angioplasty or heart surgery. This service requires prior authorization. Reportable CPT codes include 93797, 93798 or G0422 and G0423.

Cardiac Monitoring (Recording of Heart Rate and Rhythm)

A cardiologist may bill the following services if a remote monitoring company does not bill CPT code 93296:

- 93294 – Interrogation device evaluation(s) (remote), up to 90 days; single, dual, multiple lead or leadless pacemaker system, and
- 93296 – Identifies the work involved with remote monitoring technical services, including remote data acquisition(s), receipt of transmissions and technician review, technical support, and distribution of results.
- Guidelines: The CPT code for remote pacemaker monitoring covers the review and physician interpretation for all transmissions that take place within a 90-day period. CPT code 93294 should be billed in conjunction with CPT code 93296 on a schedule of 4 times per year.
- CPT code 93295 is the CPT code for defibrillator evaluation. It can be billed with CPT code 93296 if the physician is performing the service or separately by the remote monitoring company if appropriate. The 90-day period rule mentioned above also applies to this service.

Components of Devices Evaluated: The components that must be evaluated for the types of implantable or insertable cardiac devices are listed below. The required components for both remote and in-person interrogations are the same. A cardiac implantable

electronic device interrogation is a standard practice where the cardiologist can review the pacemaker or implantable cardioverter-defibrillator to ensure it is functioning appropriately and adjust as needed.

Device Evaluations Include:

Pacemaker: Programmed parameters, with or without lead(s), battery, capture and sensing function and heart rhythm.

Implantable defibrillator: Programmed parameters, lead(s), battery, capture and sensing function, presence, or absence of therapy for ventricular tachyarrhythmias and underlying heart rhythms.

Clinical Trials

If the clinical trial is provided by a contracted hospital or physician, VCHCP will pay the contracted rate, the member is responsible for the applicable cost sharing for services covered by the Plan. If the trial is provided by a non-contracted provider, VCHCP will obtain a case agreement for services covered by the Plan. The member is responsible for the applicable cost share. This service requires prior authorization. VCHCP does not cover any of the following when a member is enrolled in a clinical trial.

- The cost of an investigational drug, device, or experimental intervention which would otherwise not be provided by the Plan.
- Drugs or devices that have not been approved by the FDA and that are not associated with the Clinical Trial.
- The costs associated with managing the research related to the clinical trial, for example, data collection, analysis, and other protocol-induced costs.
- The costs that would not be covered under the member's coverage with respect to a medical procedure not involving a clinical trial.
- Trials to determine safety or dosing levels of a drug.
- Services other than health care services, such as travel, housing, companion expenses, and other nonclinical expenses.
- Items and services generally made available by the trial sponsor without charge.

Compression Stockings & Garments

The Plan does not cover over the counter (OTC) products such as support stockings. However, the Plan covers individually fitted prescription graded compression stockings or inflatable compression garments for members who: (1) had prior use of OTC products with demonstrated failure and, (2) have a qualifying medical condition (as mentioned below). Prescriptions for therapeutic compression hose must contain specific pressure gradient, expressed in mmHg. Qualifying medical conditions include but are not limited to:

- Treatment of one or more of the following complications of chronic vein insufficiency:
  - Varicose Veins (except spider veins)
  - Venous Edema
  - Venous Ulcers

- Prevention of thrombosis in immobilized patients, e.g., immobilization due to surgery (including elective orthopedic surgery, such as knee replacement), trauma, general debilitation, etc.
  - Post Thrombotic Syndrome
  - Post Sclerotherapy
  - Severe Edema in Pregnancy

Applicable HCPCS codes: A6530-A6545 (gradient compression stockings)

Related codes/services: E0676 – Pneumatic compression device

Compression stockings and garments and related items, devices, and services require prior authorization.

Dialysis Services

Dialysis is the process of removing waste products and excess fluid from the body. Dialysis is necessary when the kidneys are not able to adequately filter the blood. Dialysis allows patients with kidney failure a chance to live product lives. It is typically performed 2 to 3 times per week on an outpatient basis, including in the patient's home. Dialysis is billed on an institutional claim form and requires authorization. Dialysis has a distinct bill type (0721—0729) to reflect that the service is being performed at a freestanding dialysis center. It also has a unique set of revenue codes, such as:

- 0821 – Hemodialysis
- 0831 – Peritoneal Dialysis
- 0841 – CAPD (Continuous Ambulatory Peritoneal Dialysis)
- 0851 – CCPD (Continuous Cycling Peritoneal Dialysis)
- 0881 - (Ultra-filtration)

Other revenue codes (ancillary services) may be billed in additional to the above codes such 0250 (general pharmacy) or 0636 (detail-coded drugs) however, unless otherwise specified in the provider agreement, they are not separately reimbursed.

Physician services, such as a monthly visit to the dialysis center (i.e. 90962, ESRD related service, monthly visit) should be billed on the professional claim form and reimbursed separately as they are not part of the institutional services.

ESRD Dialysis Coordination of Benefits claim processing: Medicare becomes the primary payer 33 months after the first session of dialysis. Prior to that time, VCHCP, as the Employer Group Health Plan, pays first. The rules for COB are the same for dialysis as with any type of care. If a member receives a kidney transplant and it fails and they begin dialysis again, the Plan is then primary again for the first 33 months (this means the process starts all over again from the first date of dialysis post-transplant).

Outpatient dialysis and related physician services require prior authorization. Cost sharing is applicable.

Diagnostic Laboratory

Diagnostic laboratory can be billed on the UB04 or CMS 1500 claim form as applicable to institutional or professional services. For facility claims providers are required to bill correct revenue code/CPT or HCPCS code combinations. Incorrect combinations will be denied and will require correction by the provider. General processing guidelines include:

- Unbundling is not allowed. Providers are required to bill services within organ or disease-oriented panels when applicable.
- Specimen handling (e.g., codes 99000 and 99001) are not separately reimbursable when billed with other services.
- Proper diagnostic code (ICD) is required. Screening or preventive laboratory services should be coded accurately to ensure member cost sharing is not applied.
- Laboratory screening services may be denied if performed solely for administrative or encounter purposes (without symptom or illness), such as tests required for employment or those that are court ordered. Medical records may be requested for additional review.

Applicable Services/CPT Codes (does not represent an all-inclusive list):

- Organ or Disease Oriented Panels (80047-80081)
- Drug Assay (80305-80377, 83992)
- Therapeutic Drug Assay (80143-80299)
- Evocative/Suppression Testing (80400-80439)
- Pathology Clinical Consults (80500-80502)
- Urinalysis (81000-81099)
- Chemistry (82009-84999)
- Hematology and Coagulation (85002-85999)
- Immunology (86000-86849)
- Transfusion Medicine (86850-86999)
- Microbiology (87003-87999)
- Anatomic Pathology (88000-88099)

Applicable UB04 Revenue Codes (does not represent an all-inclusive list):

- 0300 – General
- 0301 – Chemistry
- 0302 – Immunology
- 0303 – Renal patient (home)
- 0304 – Nonroutine dialysis
- 0305 – Hematology
- 0306 – Bacteriology and Microbiology
- 0307 – Urology
- 0309 - Other

For the above codes, valid revenue code/HCPCS (CPT) combinations are required. Revenue codes missing a HCPCS (CPT) code or billed with an invalid code combination will be denied.

Diagnostic laboratory does not require prior authorization when billed at the following service locations:

- Emergency department (contracted/non-contracted providers)
- Urgent care facility (contracted/out-of-area)
- Freestanding laboratory facilities (contracted)
- Primary or Specialty provider offices (contracted)
- Acute care facilities (contracted)

Authorization is required for diagnostic laboratory services performed at tertiary care facilities, non-contracted providers for non-emergency care and for other out-of-network providers.

Doula Services

Effective 1/1/2025 VCHCP will cover doula services with a written recommendation from a physician or other licensed qualified health care professional. Prior authorization is not needed, and the doula is not required to submit the recommendation to the Plan. Doulas provide person-centered, culturally competent care that supports the racial, ethnic, linguistic and cultural diversity of our members.

Doulas are non-licensed trained professionals who provide non-medical care including various types of support such as perinatal support and guidance; health navigation; evidence-based education and practices for antepartum, postpartum, childbirth, and newborn/infant care.

Coverage for doula services also includes comfort measures and physical, emotional, and other nonmedical support provided during labor and delivery and for miscarriage, stillbirth and abortion. Doulas have a per visit cost share.

With a written recommendation from the member's physician or other qualified health care practitioner, doulas may perform the following services:

- One (1) initial visit
- Up to eight (8) additional visits that may be provided in any combination of prenatal and postpartum visits
- Up to two (2) extended three-hour postpartum visits after the end of the pregnancy

If additional postpartum visits are needed, the Plan allows up to nine (9) additional postpartum visits with a written recommendation from the member's physician or other Qualified Health Care Professional. Prior authorization is not needed, and the doula is not required to submit the recommendation to the Plan.

Non-covered services include (but are not limited to):

- Belly binding (traditional/ceremonial)
- Birthing ceremonies (i.e., seating, closing the bones, etc.)

- Group classes on babywearing
- Massage (maternal or infant)
- Still and video photography
- Placenta encapsulation
- Shopping
- Vaginal steams
- Yoga

Doula services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure.

General Coding Guidelines for Doula Services

Coding for Prenatal and Postpartum Care

Medi-Cal Codes	Code Description
Z1032	Extended initial visit 90 minutes
Z1034	Prenatal visit
Z1038	Postpartum visit
T1032	Extended postpartum doula support, per 15 minutes

Postpartum period: Doulas may provide services for up to 12 months from the end of pregnancy.

Coding for Miscarriage and Abortion Support

Medi-Cal Codes	Code Description
T1033	Miscarriage Support
59840	Abortion Support

Labor and Delivery Support

Billing codes for support during labor and delivery are limited to once per pregnancy whether or not the delivery results in a live birth.

Coding for Labor and Delivery Support

CPT code for Labor and Delivery Support	Description
59409	Vaginal delivery only
59410	Vaginal delivery including postpartum care
59514	Cesarean delivery only
59515	Cesarean delivery including postpartum care
59612	Cesarean delivery only, after previous cesarean delivery
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean section delivery
59622	Cesarean delivery only, following attempted vaginal delivery after

	previous cesarean section delivery; including postpartum care

Table of CPT/HCPCS Codes and Required ICD-10-CM Codes

As indicated in the table below, diagnostic codes are required to be billed with the CPT/ HCPCS Code(s):

CPT/HCPCS Code(s)	Required ICD-10-CM Code(s)
Z1032	Z32.2, Z32.3, Z39.1, Z39.2
Z1034	Z32.2, Z32.3
59409, 59515, 59612, 59620	Z33.1, Z39.0
59840, T1033	Z33.1
T1032, Z1038	Z39.0, Z39.1, Z39.2

Doula Telehealth Services

Doulas may bill for services provided by telehealth using either modifier 93 for synchronous audio-only or modifier 95 for synchronous video as appropriate.

Modifier XP should be appended to service codes to distinguish the doula services as being separate from provider services.

Durable Medical Equipment (DME)

The Plan provides coverage for durable medical equipment (DME) subject to limitations, exclusions, and maximum annual allowance. DME requires authorization. In general, VCHCP follows Medicare coverage guidelines and definitions. Products that can be purchased at a retail store are a benefit exclusion. Non-prescription (over the counter) DME that can be purchased without a licensed provider's prescription order for a non-prescription item, are not covered except as specifically provided in the Plan's online VCHCP Medical Policy under Home Health Care Services, Hospice Care, Durable Medical Equipment and Prosthetic and Orthotic Services. DME is defined as and is recognized as such when it meets all the following criteria:

- It is usually designed for and can withstand repeated use.
- It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience.
- It is unusually not useful to a person in the absence of sickness or injury.
- It is appropriate for home use.
- It must be related to the patient's physical disorder.
- The equipment must be used in the members' home.

Durable Medical Equipment (DME) – Replacement

Replacement DME requires prior authorization. "Replacement" refers to the replacement of one item with an identical or nearly identical item (e.g., one manual wheelchair for another; not to switch from a manual wheelchair to an electric wheelchair or a motorized scooter). VCHCP covers DME replacement if the item has been in the member's possession for its whole "lifetime". The definition of lifetime varies depending on the

type of equipment and would usually be determined by the manufacturer's published lifetime recommendation. There is a cost share for replacement DME.

Coding for DME: Applicable HCPCS codes for DME include E0100-E8002.

Modifiers:

- RA – Replacement of a DME item due to loss, irreparable damage, or theft. This is used on the first month rental claim for a replacement item.
- RB – Replacement of a part of DME as part of a repair
- KX – Documentation on File
- NU – New equipment
- NR – Equipment new at time of rental now purchased.
- RR – Rental equipment

Emergency Services

The Plan reimburses providers for emergency services for stabilization and transport of its enrollees without requiring prior authorization. The Plan may only deny emergency services if the Plan enrollee did not require emergency services, and the enrollee reasonably should have known that an emergency did not exist. Examples of emergency services include uncontrolled bleeding, chest pain, broken bones, or severe pain. Psychiatric emergencies include suicidal thoughts, hallucinations, and other mental health emergencies. Cost sharing is applicable for emergency services.

Assembly Bill (AB) 2843 (Health Care Coverage: Rape and Sexual Assault)

Effective July 1, 2025, per AB 2843, the Plan will provide coverage for emergency room (ER) medical care and follow-up health care treatment for enrollees who are treated following a rape or sexual assault without imposing cost sharing for the first nine months after enrollees initiate treatment. The Plan will apply the waiver of cost sharing if the enrollee's treating provider submits all requests for claims payments using accurate diagnosis codes specific to rape or sexual assault. When an enrollee is seen in the emergency room claim identifiers including the ICD-10-CM (diagnosis) codes listed below will alert the Plan that care was initiated for rape or sexual assault as defined by Penal Code Sections 261, 261.6, 263, 263.1, 286, 287, and 288.7. Note: The Plan already covers the initial visit for services relating to rape and sexual assault without cost share; AB 2843 expands the period of coverage where cost sharing is inapplicable.

Claim Form Identifiers

- Institutional claim form (UB04) with bill type 013x
- Revenue code 0450 (emergency department)
- Professional claim form (CMS-1500) with place of service code 23 (emergency department)

ICD-10-CM (diagnosis) Code List
T76.21: Adult sexual abuse, suspected
T76.21XA: Adult sexual abuse, confirmed, initial encounter
T76.21XD: Adult sexual abuse, confirmed, subsequent encounter

T76.21XS: Adult sexual abuse, confirmed, sequela
T76.22: Child sexual abuse, suspected
T76.22XA: Child sexual abuse, confirmed, initial encounter
T76.22XD: Child sexual abuse, confirmed, subsequent encounter
T76.22XS: Child sexual abuse, confirmed, sequela
T74.21: Adult sexual abuse, confirmed
T74.21XA: Adult sexual abuse, confirmed, initial encounter
T74.21XD: Adult sexual abuse, confirmed, subsequent encounter
T74.21XS: Adult sexual abuse, confirmed, sequela
T74.22: Child sexual abuse, confirmed
T74.22XA Child sexual abuse, confirmed, initial encounter
T74.22XD: Child sexual abuse, confirmed, subsequent encounter
T74.22XS: Child sexual abuse, confirmed, sequela
T74.51: Adult forced sexual exploitation, confirmed
T74.51XA: Adult forced sexual exploitation, initial encounter
T74.51XD: Adult forced sexual exploitation, subsequent encounter
T74.51XS: Adult forced sexual exploitation, sequela
T74.52: Child sexual exploitation, confirmed
T74.52XA: Child sexual exploitation, initial encounter
T74.52XD: Child sexual exploitation, subsequent encounter
T74.52XS: Child sexual exploitation, sequela
Z04.41 Encounter for examination and observation following alleged adult rape
Z04.42 Encounter for examination and observation following alleged child rape
Z04.81: Encounter for examination and observation of victim following forced sexual exploitation

Emergency Services - Transportation

Emergency care also includes ambulance transport (ground and air) provided through the 911 Emergency System. After a medical problem no longer requires emergency care or ceases to be an emergency and the condition is stable, any additional care the member received is considered "follow-up care." Emergency services billed by a facility are reported on an institutional claim form with bill type 013X and revenue code 0450. For physicians billing emergency services separately from a facility, charges are billed on the professional claim form with place of service code 23. Ambulance services for ground transportation include HCPCS codes A0427 (ALS1-emergency) or A0429 (BLS-emergency) when billing for a response to an "emergency" 911 call. Air ambulance claims may include HCPCS A0430 (fixed wing transport, one way), A0431 (rotary wing transport, one way) and mileage codes A0435 (fixed wing) or A0436 (rotary wing). Include remarks in box 19 to convey that the transport was provided in response to an "emergency" 911 call (a trip report is not required when these remarks are included however may be requested if needed for review). Unlisted ambulance services billed under HCPCS code A0999 require a description of service on the claim form to determine if the service or item is included in the transport or separately payable. Drugs may be separately reimbursed when billed with a HCPCS code such as J2310 (Narcan), and A0396 (ALS specialized service disposable supplies; esophageal intubation) may be billed with one unit of service for supplies such as for intubation tubing. Routine

supplies and drugs are not payable. Additional attendants (HCPCS A0424) and ambulance wait times (HCPCS A0420) will be reimbursed when medically necessary.

Enteral Nutrition Claims

Enteral nutrition consists of nutritional support given via the alimentary canal directly or through any of a variety of tubes used in specific medical circumstances. This includes oral feeding, sip feeding, and tube feeding using nasogastric, gastrostomy, and jejunostomy or other tubes. This service requires prior authorization. Applicable HCPCS code range: B4034-B4088 (Enteral Feeding Supplies and Equipment) and B9002-B9999 (Nutrition Infusion Pumps and Supplies NOC). Unlisted codes B9998 and B9999 require a description of the supply/service on the claim form and medical necessity review. Medical record documentation may be requested.

Essential Health Benefits

Basic health care, also known as Essential Health Benefits (EHB), covers a wide range of services. Covered Basic Health Care Services "Essential Health Benefits" include the following:

A. Emergency health care services rendered in both inside and outside the service area of the applicable network consistent with the Knox-Keene Act.
B. Urgent care services rendered inside and outside the service area of the applicable network consistent with the Knox Keene Act.
C. Physician services, including but not limited to consultation and referral to other health care providers and prescription drugs when furnished or administered by a health care provider or facility.
D. Hospital inpatient services, including services of licensed general acute care, acute psychiatric, and chemical dependency recovery hospitals.
E. Ambulatory care services, including but not limited to physical therapy, occupational therapy, speech therapy, and infusion therapy.
F. Diagnostic laboratory services, diagnostic and therapeutic radiologic services, and other diagnostic and therapeutic services.
G. Home health services.
H. Preventive health care services, regardless of whether an enrollee has been diagnosed with a mental health condition or substance use disorder.
I. Hospice care is, at a minimum, equivalent to hospice care provided by the federal Medicare Program.

Experimental and Investigational Procedures

Experimental and investigational procedures/services are not generally non-covered. These services (drugs, devices, therapy, or procedures) require medical necessity review. Services deemed to be non-covered will be denied for that reason.

- Copayments/coinsurance is applicable if the service is approved.
- Applicable HCPCS/CPT codes which require review include (not an all-inclusive list): 0042T-0639T (Category III Codes), HCPCS codes A9150-A9999 (Administrative, Miscellaneous, and Investigational), and miscellaneous services such as unlisted CPT codes.

Consistent with § 1370.4 of the Knox Keene Act experimental or investigational procedures/services may be approved if certain criteria is met and the member is to be treated as part of a clinical trial (refer to section within this document addressing Clinical Trial Claims Processing and online at https://www.vchealthcareplan.org/providers/medicalPolicies.aspx for additional details).

Gastric Laboratory Services

Specialized gastrointestinal (GI) services performed in a GI laboratory should be billed with revenue code 0750 – Gastrointestinal Services. This includes services such as esophageal motility studies billed under CPT codes 91010 and 91013. No authorization is required when performed by a contracted provider except for tertiary care.

Genetic Testing

Genetic testing requires prior authorization and has member cost sharing except in the case of preventive services such as those billed by California's Genetic Disease Screening Program that screens for chromosomal abnormalities (e.g., CPT code 81420, fetal chromosomal aneuploidy). Genetic testing is the analysis of DNA, RNA, chromosomes, proteins, and other genetic materials to identify changes that may cause or contribute to disease. It is an essential tool in medicine enabling doctors to diagnose, treat and prevent a wide range of health conditions.

Coding – CPT codes include but are not limited to:

- Tier 1 Molecular Pathology: 81105-81364
- Human Leukocyte Antigen (HLA) Typing: 81370-81383
- Tier 2 Molecular Pathology Procedures: 81400-81408, 81479*
- Genomic Sequencing Procedures: 81410-81471
- Multianalyte Assays with Algorithmic Analyses: 81490-81596, 81599*

(*) Unlisted codes require a description of the test on the claim form and submission of medical records for medical necessity review.

Coding for Genetic Testing (Not an all-inclusive list)

Revenue codes when reported on institutional claim form include: 0311 – Cytology.

Professional claim form criteria: Place of service code = 81 (Independent Laboratory)

Applicable modifiers: 59 – Distinct procedural service

Related Codes and Services include but are not limited to:

- CPT code 96040: Medical genetics and genetic counseling services; each 30 minutes face-to-face with patient and/or family.
- Proprietary Laboratory Analyses Codes (a set of CPT codes approved by the AMA)

Cancer Biomarkers

Biomarker Testing (State Bill (SB) 535) – Requires health plans on or after July 1, 2022, to remove prior authorization requirements for biomarker testing for an enrollee with

advanced or metastatic stage 3 or 4 cancer or cancer progression or recurrence in the enrollee with advanced or stage 3 or 4 cancer. Therefore, claims received from specialized laboratories containing any cancer-related diagnoses and qualifying procedure codes will no longer require Utilization Management (UM) review or authorization. Cost sharing applies.

Biomarker testing is for patients who have cancer (solid tumors and blood cancer). It is a way to look for genes, proteins, and other substances (called biomarkers or tumor markers) that can provide information on cancer to help decide treatment options. Biomarker testing is different from genetic testing that is used to find out if a person has inherited mutations that make them more likely to get cancer. Applicable cancer diagnostic codes include:

C00-C14	Malignant neoplasms of lip, oral cavity and pharynx
C15-C26	Malignant neoplasms of digestive organs
C30-C39	Malignant neoplasms respiratory and intrathoracic organs
C40-C41	Malignant neoplasms of bone and articular cartilage
C43-C44	Melanoma and other Malignant neoplasms of skin
C45-C49	Malignant neoplasms of Mesothelial and soft tissue
C50	Malignant neoplasms of breast
C51-C58	Malignant neoplasms of female genital organs
C60-C63	Malignant neoplasms of male genital organs
C64-C68	Malignant neoplasms of urinary tract
C69-C72	Malignant neoplasms of eye, brain, other parts of central nervous system
C73-C75	Malignant neoplasms of thyroid and other endocrine glands
C7A	Malignant neuroendocrine tumors
C7B	Secondary neuroendocrine tumors
C76-C80	Malignant neoplasms of ill-defined, other secondary and unspecified sites
C81-C96	Malignant neoplasms of lymphoid, hematopoietic and related tissue
D00-D09	In situ neoplasms
D10-D36	Benign neoplasms, except benign neuroendocrine tumors
D3A	Benign neuroendocrine tumors
D37-D48	Neoplasms unc. behavior, polycythemia vera/Myelodysplastic syndromes
D49	Neoplasms of unspecified behavior
Z85-Z85.9	History of cancer diagnosis codes

Procedure Codes (abbreviation key included below) – An example list of codes includes the following tests:

CPT Code	Description	Cancer Type
81120	IDH1 Common Variants	Brain, AML
81121	IDH2 Common Variants	Brain, AML
81170	ABL1 Gene Analysis Kinase Domain Variants	ALL, CML, CMML
81175	ASXL 1 Gene Analysis Full Gene Sequence	AML

81176	ASXL 1 Gene Analysis Targeted Sequence Analysis BCR/ABL1 Major Breakpoint	AML
81206	Qualitative/Quantitative BCR/ABL1 Minor Breakpoint	ALL, CML, CMML
81207	Qualitative/Quantitative BCR/ABL1 Other Breakpoint	ALL, CML, CMML
81208	Qualitative/Quantitative	ALL, CML, CMML
81210	BRAF Gene Analysis V600E Variant	Peritoneum
81218	CEBPA Gene Analysis Full Gene Sequence	AML
81261	IGH@ Rearrange Abnormal Conal Amp	CLL
81262	IGH@ Gene Rearrange Direct Probe	NHL
81263	IGH@ Var Region Somatic Mutation Analysis	HCL, CLL
81270	JAK2 Gene Analysis P.VAL617PHE Variant	AML, CML, CMML
81272	KIT Gene Analysis Targeted Sequence Analysis	Melanoma,.
81273	KIT Gene Analysis D816 Variant(s)	AML, CML, CMML,
81275	KRAS Gene Analysis Variance in Codons 12 and 13	AML, CML, CMML
81276	KRAS Gene Analysis Additional Variant(s)	AML, CML, CMML

Abbreviation Key:

ALL – Acute lymphocytic leukemia
AML – Acute Myeloid Leukemia or Acute Myelogenous Leukemia
CLL – Chronic Lymphoid Leukemia
CML – Chronic Myelogenous Leukemia
CMML – Chronic Myelomonocytic Leukemia
HCL – Hairy Cell Leukemia

Home Health Care

Home health care means services provided in the home by registered nurses, licensed vocational nurses, and licensed home health aides; physical, occupational and speech therapists. The member must be homebound because of illness or injury and the care must not be considered custodial.

Services are limited to those authorized by the Plan: Maximum 3 visits per day, up to 2 hours per visit unless otherwise authorized (nurse, social worker, physical/occupational/speech therapist) or 4 hours of non-custodial home health aide services furnished by a licensed home health aide. Additional hours on top of the two-hour visit are payable at a one-hour visit rate. These services are billed on an institutional claim form with bill type 032x. The benefit for home health (nursing and rehabilitation) is a 100-visit maximum per plan benefit year.

Surgical Dressings Billed by Home Health Agencies on the UB-04

Per CMS products that are eligible to be classified as a surgical dressing for qualified wounds (based upon wound type, wound location, wound size/depth, amount of drainage, and other relevant factors) are defined as:

- Primary dressings - Therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin.
- Secondary dressings - Materials that serve a therapeutic or protective function and that are needed to secure a primary dressing. Items such as adhesive tape, roll gauze, bandages, and disposable compression material are examples of secondary dressings.

Some items, such as transparent film, may be used as a primary or secondary dressing.

Revenue code 0623 (non-routine wound care supplies) may be billed; such items that are generally eligible for separate reimbursement, however items considered to be routine supplies (such as those billed under revenue code 0270) are not.

Code examples include (not an all-inclusive list): A6010, A6011, A6021, A6022, A6023, A6024, A6154, A6196, A6197, A6198, A6199, A6203, A6204, A6205, A6206, A6207, A6208, A6209, A6210, A6211, A6212, A6213, A6214, A6215, A6217, A6218, A6219, A6220, A6221, A6222, A6223, A6224, A6228, A6229, A6230, A6231, A6232, A6233, A6234, A6235, A6236, A6237, A6238, A6239, A6240, A6241, A6242, A6243, A6244, A6245, A6246, A6247, A6248, A6251, A6252, A6253, A6254, A6255, A6256, A6257, A6258, A6259, A6261, A6262, A6266, A6402, A6403, A6404, A6441, A6442, A6443, A6444, A6445, A6446, A6447, A6448, A6449, A6450, A6451, A6452, A6453, A6454, A6455, A6456 and A6457.

Modifiers A1-A9 were established to indicate that a particular item is being used as a primary or secondary dressing as well as to indicate the number of wounds on which that dressing is being used. If a dressing is not being used as a primary or secondary dressing on a surgical or debrided wound, the use of the A1-A9 modifiers would be inappropriate. Dressings for surgical or debrided wounds must include one of the A1-A9 informational modifiers. The correct modifier to use is the number that corresponds to the number of wounds the dressing will be used for, not the number of wounds the beneficiary has.

Surgical Dressing Modifier Descriptions:
A1 – Dressing for one wound, A2 – Dressing for two wounds, A3 – Dressing for three wounds, A4 – Dressing for four wounds, A5 – Dressing for five wounds, A6 – Dressing for six wounds, A7 – Dressing for seven wounds, A8 – Dressing for eight wounds, A9 – Dressing for nine or more wounds.

Wound Care in the Home

Fully integrated wound and dermatology care provided to patients in the home setting requires authorization. With this type of treatment providers can prevent most wound and skin related hospital admissions with a focus on helping to prevent wounds from occurring and further progression of wounds and skin-related conditions; they specialize

in complex chronic wounds and non-healing dermatologic conditions which can include but are not limited to diabetic ulcers, pressure ulcers and traumatic wounds. Specialized treatments may include bedside debridement, wound vac assistance, wound dressing, and skin grafting. This service is billed on the professional claim form with place of service code 12 (home). Debridement CPT codes include 11000-11012 and 11042-11047. Wound care management is reported under CPT codes such as 97597, 97598, 97602, 97605, 97606, 97607, and 97608 representing negative pressure wound therapy. Other reportable CPT codes may include 29580 (strapping; Unna boot) or 97610 (low frequency, non-contact, non-thermal ultrasound). This service has a cost share.

Infertility Services

Other than fertility preservation for iatrogenic infertility which is covered at 100% as a regular health benefit with the same copays as it would have for any other normal medical/surgical health benefit, VCHCP covers 50% of basic diagnostic testing, injections, and treatments for infertility. Covered benefits include reasonable and necessary services associated with the diagnosis of infertility as outlined in VCHCP's Medical Policy, "Infertility: Treatment of." Non-covered services include artificial insemination, whether from a spouse/partner or donor, penile implants, reversal of voluntary sterilization, male or female, any form of in-vitro fertilization, IVIG for recurrent spontaneous abortion, and ovulatory stimulants, repeat lab tests or ultrasounds when used to prepare for Assisted Reproductive Technology services. Covered infertility services require prior authorization.

Infertility, Iatrogenic:

Fertility preservation for iatrogenic infertility is covered at 100% of regular health benefits. Fertility preservation is the process of saving or protecting eggs, sperm, or reproductive tissue so that a person can use them to have children in the future. Iatrogenic infertility is defined as an impairment of fertility caused by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes. Iatrogenic infertility requires prior authorization for medically necessary services such as standard fertility preservations services which include:

- Retrieval of gametes (female gametes (ova, egg cells) and male gametes (sperm) exclusive from the enrollee.
- Two attempts of embryo (female egg cell fertilized by male sperm) creation.
- Up to two attempts to retrieve gonadal tissue, excluding any experimental or investigational approaches (subject to review under Section 1370.4 of the Health & Safety Code).
- Cryopreservation and storage (*) of sperm, oocytes (eggs before maturation), gonadal tissue (reproductive glands), and embryos based upon age qualifications of the patient).

(*) VCHCP is not required to cover storage for periods of time when the enrollee is not enrolled in the plan. If an enrollee changes health plans during the covered storage period, the enrollee's new health plan shall cover storage for the remainder of the applicable storage time frame to the extent required by law.

Coding: Applicable diagnosis: Z31.84 (Encounter for fertility preservation procedure). CPT codes may include but are not limited to such services as:

- 89337 (cryopreservation)
- 89342 (storage (per year) for embryo(s)
- 89253 (assisted embryo hatching, any method)
- 76830 (ultrasound, vaginal)
- Sperm analysis presence, motility and count procedures (e.g., 89300, 89310 and 89320).

Any unlisted female and male genital and reproductive medicine procedures billed such as CPT codes 55899, 58999 and 89398 require a description of the service on the claim form and medical records for medical necessity review.

Infusion (IV) Therapy in the Facility Setting

In the hospital, IV therapy is commonly used when a patient cannot take medications orally or for treatments where an intravenous route is more effective. Some examples are treating serious infections, cancer, dehydration, gastrointestinal diseases, or autoimmune disorders. Except for emergency services IV therapy requires authorization. Per CPT and CMS guidelines, heparin flushes, IV flushes of any type, and solutions used to dilute or administer substances, drugs, or medications are included in the administration service. These items are considered supplies and are not eligible for separate reimbursement and not separately billable. If performed to facilitate the infusion or injection or hydration, the following services and items are inclusive (not separately billable): Use of local anesthesia, IV start, access to indwelling IV, subcutaneous catheter or port, flush (IV flushes) at conclusion of infusion and standard tubing, syringes, and supplies.

Intravenous therapy is billed under revenue code 0260.

Chemotherapy

Chemotherapy is a drug treatment that uses powerful chemicals to kill fast-growing cells in the body. Chemotherapy is most often used to treat cancer, since cancer cells grow and multiply much more quickly than most cells in the body. This service requires prior authorization and has a cost share.

Applicable revenue codes for institutional claim form billing include:

- 0331 – Chemotherapy administration, injection
- 0332 – Chemotherapy administration, oral
- 0335 - Chemotherapy administration - IV

CPT Codes Include (Not an all-inclusive list):

- 96360-96375, 96377
- 96401-96425

Chemotherapy Drugs HCPCS Code range: J9000-J9999

Nutritional Counseling

Nutritional counseling does not require prior authorization when performed by a contracted provider.

Medical nutritional counseling therapy for dietary counseling provided in an outpatient setting by a state licensed or certified dietitian or nutritional professional or physician is

considered medically necessary if the medical appropriateness criteria are met. Medical nutritional therapy for dietary counseling is considered medically appropriate for such conditions (not an all-inclusive list) as:

- Diabetes with a lack of previous diabetes outpatient self-management training services, or
- Elevated serum fasting cholesterol, particularly with coronary heart disease or other cardiovascular disease, or
- Chronic diseases/conditions in which dietary adjustment has a therapeutic role such as celiac disease, phenylketonuria, or seizures, or
- Morbid obesity with a BMI greater or equal to 40.

Coding: Applicable diagnostic codes include but are not limited to E66.9 (obesity, unspecified) and E66.01). CPT/HCPCS codes include 97802, 97803 and S9470. Cost sharing is not applicable for obesity diagnoses.

Oral & Maxillofacial Surgeon Services

Maxillofacial surgeons, sometimes called oral and maxillofacial surgeons, are trained to handle a wide variety of conditions and injuries that affect the head, neck, mouth, jaw, and face. Maxillofacial surgeons are qualified to treat a number of conditions related to the head and neck area, including but not limited to:

- Misaligned jaws
- Impacted wisdom teeth
- Oral reconstructive surgery
- Cancers of the head and neck

Contracted providers under the Direct Referral Process may perform the following services without requesting prior authorization: Office visits (CPT codes 99202-99205 and 99211-99215 and c (panoramic x-ray, CPT code 70355).

An example of services performed by this specialty that require authorization includes but is not limited to:

- Biopsy of maxilla/facial bone (CPT code 21030)
- Le Fort I osteotomy (CPT code 21141)
- Closed reduction maxillary fracture (CPT code 21423)
- TMJ arthroscopy (CPT code 29804)
- Unlisted services CPT code 41899 for covered extractions of soft tissue or erupted teeth required a description of the service on the claim form.
- Anesthesia and pain control billed under dental anesthesia CPT code 00170

Orthotics (HCPCS Codes L1000-L3999)

Orthotics are usually rigid or semi-rigid supports, splints or braces for the support of weak or ineffective joints or muscles. Their purpose is to protect, restore or improve function. They are also used to restrict or eliminate motion in a diseased or injured part

of the body. Orthotics are covered based on medical necessity when provided by a provider authorized by the Plan.

Examples of orthotics that the Plan covers include but are not limited to therapeutic footwear, corrective shoes, shoe inserts, arch supports and foot orthotics for members with diabetes (Refer to the Plan's Foot Orthotic Policy for details regarding coverage for therapeutic shoes for diabetics at www.vchealthcareplan.org/Provider Connection).

Also covered is special footwear for foot disfigurement including, but not limited to, disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by an accident or developmental disability and congenital foot deformities and therapeutic shoes if they are an integral part of a covered leg brace and are medically necessary for the proper functioning of the brace (Refer to the Foot Orthotic Policy for further details at www.vchealthcareplan.org/Provider Connection).

Examples of some orthotics not covered by the Plan include the following exclusions:

- Non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts.
- Prescription Orthotics (other than those covered above) that can be purchased at a retail store, on-line or at a specialty store such as a back brace, boot walker or knee braces.
- Orthotics that are to be used for sports-related activities intended to prevent injury or reinjury related to engaging in said sport.

Podiatrists are required to request prior authorization for orthotics provided in-office. Contracted orthopedists may dispense selected orthotics as detailed within the Plan's Prior Authorization Reduction List of Services.

Ostomy Supplies

Ostomy refers to a surgically formed artificial opening that serves as an exit for a stoma that the surgeon has made from the small intestine, large intestine, or urinary bladder to the outside of the body. Ostomy supplies are categorized as devices used by individuals with a surgically created opening (stoma) to divert urine, feces, or ileal contents outside of the body. They can also be used for drainage of an abnormal opening or from a malfunctioning organ (e.g., fistula). The Plan covers ostomy supplies as needed by the member when all the following criteria are met:

- The ostomy supplies are supplied to replace all or part of an absent body organ or the function of a permanently inoperative or malfunctioning organ.
- The ostomy supplies are prescribed by an eligible health care provider.
- The ostomy supplies are supplied by an eligible ancillary provider.

This service requires prior authorization.

Applicable HCPCS code range: A4360-A4435.

Palliative Care

Palliative care is an interdisciplinary, patient and family centered approach to care that promotes quality of life in the context of advanced or life-threatening illness. Palliative care focuses on control of pain and symptoms with attention to the psychosocial and spiritual experiences of adapting to advanced or life-limiting illness. A patient must qualify for palliative care service or have a serious diagnosis and death would not be unexpected in a year. Qualified conditions include but are not limited to medical conditions such as congestive heart failure, obstructive pulmonary disease, and advanced cancer. This service requires prior authorization and has a cost share. Applicable CPT codes include Evaluation & Management services.

Physical Therapy (PT) and Occupational Therapy (OT)

Effective 1/1/19, For PT providers, an initial 8 direct referral visits plus an additional 16 PT visits are allowed without prior authorization. Any visits for additional therapy beyond the 24 will require prior authorization or be denied.

Effective 1/1/19, For OT providers, an initial 8 direct referral visits plus an additional 16 PT visits are allowed without prior authorization. Any visits for additional therapy beyond the 24 will require prior authorization or be denied.

When performed at a tertiary care facility or by a non-contracted provider all PT and OT services require prior authorization.

Non-covered services include CPT code 97010 (application of cold packs) – This service will be denied as inclusive to the primary therapy service(s).

Provider Agreements with Medicare rates will not be reimbursed for CPT code 97014 (electrical stimulation); it does not have a Medicare rate (G0283 is the accepted code). Claims submitted with CPT code 97014 will be denied and require correction.

PT and OT services billed at facilities such as an outpatient hospital department require submission on an institutional claim form. Freestanding facilities not connected to a hospital should use the professional claim form to bill their services.

Proprietary Laboratory Analyses

Proprietary Laboratory Analyses (PLA) codes are CPT codes approved by the American Medical Association (AMA). They are a set of alpha-numeric CPT codes with a corresponding descriptor for labs or manufacturers that want to identify their test more specifically. The AMA provides the PLA codes and the laboratory or manufacturer that offers the test must request it from them. Tests with PLA codes must be performed on human specimens and must be requested by the clinical laboratory or manufacturer that offers the test. This unique set of codes generally does not have a Medicare rate available for reimbursement therefore requiring a case agreement or claims repricing. This service requires prior authorization.

Prosthetics (HCPCS Codes L5999-L8699)

Prosthetics are defined as an artificial device which replaces all or a portion of a part of the human body designed to improve a specific body function. These devices are medically necessary because a part of the body is permanently damaged, is absent or is malfunctioning.

Examples of covered prosthetics include:

- Initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy.
- Prosthetic devices to restore and achieve symmetry incident to mastectomy.
- Intraocular lenses after cataract surgery
- Visual aids (excluding eyewear) to assist visually impaired with proper dosing of insulin.
- Fitting, repair, replacement and maintenance of prosthetic devices.
- Eyeglasses or contact lenses post cataract surgery.
- Non-prescription (OTC) prosthetics that can be purchased without a licensed provider's prescription specifically provided under Home Health Care Services or Hospice Care. Under Hospice Care, prosthetics are covered to the extent reasonable and necessary for the palliation and management of terminal illness and related conditions.

Covered prosthetics require prior authorization.

Applicable modifiers include LT (left side of body), RT (right side of body).

Examples of non-covered prosthetics: More than one device for the same area of the body, dental appliances, eyeglasses or contact lenses not related to cataract surgery, prosthetics that can be purchased OTC at a retail store (unless there's an exception situation which requires medical necessity review by the Plan's Medical Director) and prosthetics for cosmetic purposes.

Public Health Services

Providers contracted with the Plan perform public health services related to tuberculosis (TB) screening and treatment. Treatment includes observing patients taking oral TB medications which requires prior authorization. Cost sharing is applicable.

Screening for TB is considered preventive and does not have a cost share or require authorization (reportable with diagnosis code Z11.1 (Encounter screening for respiratory tuberculosis)). CPT code 86580 is used to describe all intradermal TB tests, including TB skin tests. Administration of the PPD solution is inclusive to 86580; CPT code 86580 should be reported alone absent of any vaccine or medication administration codes. It is inappropriate to bill vaccine administration codes like 90471 with 86580.

Observation of medication compliance billed under HCPCS code H0033 (oral medication administration, direct observation for oral TB medications) can be billed with POS code 02 (telehealth other than home) or 10 (telehealth, home).

Pulmonary Rehabilitation

A pulmonary rehabilitation outpatient program is a comprehensive program that generally includes team assessment, participant training, psychosocial intervention, exercise training, and follow-up. This service requires prior authorization and has a cost share. Coding for pulmonary rehabilitation includes but is not limited to the following:

CPT:

94625	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)
94626	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)

HCPCS:

G0237	Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes
G0238	Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, each 15 minutes (includes monitoring)
G0239	Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, 2 or more individuals (includes monitoring)
S9473	Pulmonary rehabilitation program, non-physician provider, per diem

A valid ICD-10 diagnostic code such as the following must also be billed to support medical necessity:

J42	Unspecified chronic bronchitis
J43.0 – J43.9	Emphysema
J44.9	Chronic obstructive pulmonary disease, unspecified

Facility claims: The UB04 revenue code for reporting pulmonary rehabilitation services is 948.

Radiation Oncology (Radiotherapy/Radiation Therapy)

Radiation therapy, also called radiotherapy, is a type of cancer treatment. This treatment uses beams of intense energy to kill cancer cells. Radiation therapy most often uses X-rays, but other types of radiation therapy exist, including proton radiation. This service requires prior authorization and has a cost share.

Applicable CPT codes include but are not limited to:

- Evaluation & Management
- Clinical Treatment Planning (77261-77263)
- Simulation (77280-77290)
- Respiratory Management Simulation (77295)
- Basic Dosimetry (77300)
- Special Dosimetry (77331)
- IMRT Dose Planning (77301)
- MLC Device for IMRT (77338)
- Teletherapy Isodose Plan (77316-77318)
- Brachytherapy Isodose Plan (77316-77318)
- Special Teletherapy Port Plan (77321)
- Treatment Devices (77332-77334)
- Continuing Medical Physics Consult (77336)
- Special Medical Radiation Physics Consult (77370)

- Radiation Treatment Delivery, Superficial (77401)
- Radiation Treatment Delivery (G Codes) (G6003-G6014)
- IMRT Treatment Delivery (77385-77386)
- IMRT Treatment Delivery (G Codes) (G6015-G6016)
- Port Images (77417)
- IGRT (77387)
- IGRT (G Codes) (G6001, G6002, G6017)
- CT Guidance (77014)
- Proton Treatment Delivery (77520-77525)
- Neutron Beam Treatment Delivery (77422-77423)
- SRS Treatment Delivery (77371-77372)
- SBRT Treatment Delivery (77373)
- Hyperthermia (77600-77620)
- LDR Brachytherapy (77778)
- HDR Brachytherapy (77770-77772)
- IORT (77424-77425)
- Surface Application of Radiation Source (77789)
- Infusion or Installation of Radioelement Solution (77750)
- Intracavity Radiation (77761-77763)
- Supervision and Handling (77790)
- Radiation Treatment Management (77427, 77431)
- SRS Treatment Management (77432)
- SBRT Treatment Management (77435)
- Intraoperative Treatment Management (77469)
- Special Treatment Procedure (77470)

For institutional claim form billing revenue code 0333 (Radiation therapy) is used with bill type 13X.

Transportation Services

Ground Ambulance

Ground ambulance transportation is covered by the Plan in the following circumstances, subject to cost sharing:

- To transport a person from the place where he/she is suddenly stricken by a disease or injury to the first hospital emergency room or hospital where treatment will be given. When the patient's circumstances permit, the patient may be transported to a contracted hospital.
- To transport a patient from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the patient, when ordered by the Plan.
- To transport a patient from hospital to home, skilled nursing facility or nursing home when the patient cannot be adequately or safely transported in another way without endangering the patient's health, whether or not such other transportation is actually available.

- To transport a patient from home to hospital for medically necessary inpatient or outpatient treatment of the injury or illness involved. Coverage to the patient's home requires prior Plan approval, and the home must be within the service area of the Plan. Coverage of ground transportation requires prior Plan approval except in life threatening emergencies or when transportation follows a paramedic response to a 911 call. When transport is medically necessary, the Plan will provide the lowest level of transport appropriate for the condition of the member.

Air and Water Ambulance Transport

The Plan covers air and water ambulance transport in the following circumstances, subject to cost sharing:

- Patient requires transport to a hospital or from one hospital to another because the first hospital does not have the required services and/or facilities to treat the patient; and ground ambulance transportation is not medically appropriate because of the distance involved, or because the patient has an unstable condition requiring medical supervision and rapid transport. Except in life threatening emergencies, coverage of air and water ambulance transport requires prior Plan approval.

Applicable HCPCS codes for ambulance transport include (not an all-inclusive list): A0426, A0427, A0428, A0429, A0433, A0434, A0425.

Ambulance Service Modifiers:

For ambulance service, one-digit modifiers are combined to form a two-digit modifier that identifies the ambulance's place of origin with the first digit, and ambulance's destination with the second digit.

One-digit modifiers:

-D: Diagnostic or therapeutic site other than -P or – H when these are used as origin codes

-E: Residential, domiciliary, custodial facility (other than an 1819 facility)

-G: Hospital-based dialysis facility (hospital or hospital related)

-H: Hospital

-I: Site of transfer (for example, airport or helicopter pad) between types of ambulance

-J: Non-hospital-based dialysis facility

-N: Skilled nursing facility (SNF)

-P: Physician's office

-R: Residence

-S: Scene of accident or acute event

Ambulance Place of Service Codes:

-41: Ambulance, ground
-42: Ambulance, air, or water

Assembly Bill (AB) 716

Effective January 1, 2024, AB 716 requires a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2024, to require an enrollee or insured who receives covered services (including both emergency and nonemergency services) from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the enrollee or insured would pay for the same covered services received from a contracting ground ambulance provider. The bill prohibits a noncontracting ground ambulance ground ambulance provider from sending to collections a higher amount and limits the amount an enrollee or insured owes a noncontracting ground ambulance provider to no more than the in-network cost sharing amount. The bill requires a plan or insurer to directly reimburse a noncontracting ground ambulance provider for ground ambulance services the difference between the in-network cost-sharing amount and an amount described, as specified, unless it reaches another agreement with the noncontracting ground ambulance provider. Providers will be informed of the enrollee's in-network cost-sharing amount at the time of payment per the Plan's Remittance Advice (RA) which discloses that the enrollee's coverage is regulated by the DMHC. The enrollee will be informed of the in-network cost-sharing amount at the time of payment per the Plan's Explanation of Benefits (EOB) which discloses that the enrollee's coverage is regulated by the DMHC.

Non-Emergency Medical Transport

The Plan covers authorized non-emergency medical stretcher and wheelchair van transportation to and from medical facilities, private residences, nursing homes and retirement centers. This transportation is provided by the Plan when deemed medically necessary and transportation cannot be safely provided by private means. This service is reportable under HCPCS code A0130.

Urgent Care

Urgent care means any covered service necessary to prevent serious deterioration of the health of a member resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member is able to see their PCP. Members may only obtain urgent care with contracted providers in the Plan's service area. When out-of-area members may obtain urgently needed care from any urgent care provider. Cost sharing is applicable.

Coding for Urgent Care Services:

- Urgent care performed in a facility setting should be billed with revenue code 0456 on the CMS-1450.
- When reporting professional services use place of service code 20 and office visit codes (99202-99205 (new patient)) and 99211-99215 (established patient)).

The following codes are not payable when billed by contracted urgent care facilities. Non-contracted provider claims billed with these codes will be reviewed on an individual basis:

- S9083: Global Fee for Urgent Care Centers – This code is used to bill all urgent services as a one size fits all global service for flat rate reimbursement. This reimbursement methodology is not recognized/utilized by the Plan.
- S9088: Services Provided in an Urgent Care Center – This is an "add-on" code used for all unscheduled, walk-in visits billed in conjunction with the service.

Global Surgical Package

For the Global Surgical Package one payment is issued for all care associated with a surgical procedure. The payment is based on three phases of a surgical procedure, which include: Preoperative evaluation, the Intra-operative procedure, and Post-operative care for a time-period of zero (0), ten (10), or ninety (90) days. The three types of procedures that carry a global surgical package include: Simple procedures (zero global period), Minor surgical procedures (10-day global period), and Major surgical procedures (90-day global period). When a surgeon provides all three phases of the patient's care for a surgical procedure the surgeon will bill the surgical procedure and receive payment for the entire package. Services provided pre-operatively, intra-operatively and post-operatively are considered part of the surgical package, whether rendered by the surgeon or by members of the same medical group within the same specialty.

Services that are part of the Global Surgical Package include:

- One preoperative visit.
- Intra-operative care, including the surgery.
- Post-operative Care (i.e.; removal of sutures, staples, drains, tubes, casts, etc., and any care required by the surgeon due to postoperative complication or problems that do not require the patient to be taken back to the operative room for additional procedures). Supplies used to treat any postoperative surgical complications or treatments, unless specified as exclusive.
- Post-operative pain management.
- Office visits related to the recovery from the surgical procedure and complications from the surgical procedure.

When a patient is seen and services are related to the recovery and/or complications from the surgical procedure, CPT code 99024 should be reported to indicate this was a service related to the surgery.

Services that are not part of the Global Surgical Package include:

- The initial consultation or the Evaluation/Management service in which the decision for surgery is made.
- Return trips to the operating room for complications from the surgery. If a return trip to the operating room is required, then the global surgical period starts over again with the second surgery.

- Diagnostic procedures such as x-rays or other imaging services, laboratory, or durable medical equipment.
- Office visits for medical conditions that are unrelated to the surgical procedure.
- Medication management for conditions unrelated to the surgical procedure.

When billing for services performed during the global surgical period that are not related to the surgical procedure or complications and recovery from it, specific modifiers should be appended to the procedure code to indicate that the service provided is unrelated to the global surgical period which the patient is currently in.

Pap Smear Obtained During Preventive Medicine Services

If a patient presents for a preventive medicine service, the pelvic examination and clinical breast exam is part of the age and gender appropriate physical examination, as described by CPT codes 99381—99397. However, for a screening pap smear, the HCPCS code for the service of obtaining the screening pap smear; Q0091, may be used. Do not bill HCPCS code G0101; pelvic and clinical breast exam, on the day of a preventive medicine visit.

Personal Care Items

Personal care items used for patient convenience are not reimbursable. Examples include but are not limited to deodorant, lotion, mouthwash, powder, shampoo, soap, telephone calls, television, toothbrush and toothpaste. Items used for the patient which are needed as a direct result of a procedure or test are considered incidental to the room and board or procedure charges and are not separately reimbursable or billable to the patient. Examples include but are not limited to bedpans, hot water bottles, icepacks, linens, pillows, and urinals. For the UB-04, patient convenience items that are billed under the following revenue codes will be denied: 0990 (general), 0991 (cafeteria/guest tray), 0992 (private linen service), 0993 (telephone), 0994 (TV/radio), 0995 (nonpatient room rentals), 0996 (late discharge kits), 0997 (admission kits), 0998 (beauty shop/barber) and 0999 (other).

Portable Charges

Portable charges are included in the reimbursement of the procedure, test or x-ray and are not separately reimbursable.

Preparation (Set-Up) Charges

Charges for set-up, equipment, or materials in preparation for procedures or tests are included in the reimbursement of the procedure or test.

Private Payer Codes

Private payer codes are temporary national codes established by private payers for private payer use. Commercial payers develop these codes to report drugs, services, and supplies. Medicare does not reimburse these codes. Private payer codes reimbursed by VCHCP include, for example, home infusion therapy reportable under S5497, S5498, S5501, S5502, S5517, S5518, S5521, S5522 and S5523. Nursing care (specialty services

– skilled nursing) is reported with code S9123 when applicable to the provider agreement. These services require authorization. Sales tax reported under S9999 is generally non-coved and will be reviewed on a case-by-case basis. Other various services billed under private payer codes are not covered and will be denied; this includes but is not limited to S9970 (health club membership), S8940 – Equestrian/hippotherapy, and S5130 – homemaker services.

Robotic Assisted Surgery

VCHCP considers the use of robotic technology to be a technique that is integral to the primary surgery being performed, and therefore, not separately reimbursable. Charges that are not eligible for separate or additional reimbursement are, as follows: Increased operating room unit cost charges for the use of robotic technology, charges billed under CPT or HCPCS codes that are specific to robotic assisted surgery, including, but not limited to HCPCS S2900 (surgical techniques requiring use of robotic surgical system).

This section has been updated to include computer assisted techniques. Computer assisted techniques are considered integral to the primary surgical procedure and are not separately reimbursed. This includes but is not limited to the following procedures:

0054T: Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images.

0055T: Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images.

Self-Administered Drugs

Self-administered drugs are drugs that a patient would take by mouth or administer to themselves. Such drugs include, but are not limited to oral medications, insulin, eye drops and topical treatments. Medications administered to a patient that do not require direct supervision by a qualified provider or licensed/certified health professional are considered self-administered drugs and are a not covered benefit when used in a hospital outpatient setting. These drugs are billed under revenue code 0637 to differentiate them from drugs billed and covered under revenue code 0250. Claims, however, are reviewed to identify exceptions such as insulin administered in an emergency to a patient in a diabetic coma. Self-administered drugs are not payable in an ambulatory surgery center when billed with revenue code 0360, 0361 and 0490. Examples of cases where a drug is not directly related and integral to a procedure or treatment and would not be considered a packaged supply include when drugs are given to a patient for their continued use at home after leaving the hospital or in a situation where a patient who is undergoing surgery needs his daily hypertension medication, the medication would not be treated as a packaged supply. Drugs furnished outpatient for therapeutic purposes are non-covered unless those drugs are put directly into an item of durable medical equipment. Drugs billed under revenue code 0637 during inpatient admission are generally covered.

Reporting CPT code 27096 or HCPCS code G0260

These codes are both used for sacroiliac joint (SI) joint injections but reported differently depending on the provider type. For physician coding, CPT code 27096 is reported on a 1500 claim form for SI joint injection, however CPT code 27096 is not a covered service for an ASC facility and not recognized under OPPS. G0260 is the Medicare approved facility ASC procedure code reportable on the UB04 claim form for SI joint injections. Ambulatory Surgical Center or outpatient hospital claims which report CPT code 27096 billed in combination revenue codes 0490 or 0360 will be denied as invalid; a corrected claim must be submitted using G0260.

Correct Modifier Usage for Laboratory and Radiology Claims
Laboratory – Pathology Services

When multiple laboratory (pathology) services described by a single CPT code are provided to a patient on one service day by the same provider, the provider should either bill the exact quantity of units needed for the CPT code on one detail line; or for multiple detail lines utilize CPT modifiers such as -59 to indicate that the second and additional repeat procedure codes are distinct. Guidelines for usage of CPT modifiers should be followed as advised by the AMA.

Pathology claim example billing 2 units of service for CPT code 88305:

Correct: Bill one line with CPT code 88305 and 2 units.
Incorrect: Two lines with CPT code 88305 with 1 unit each for the same date of service (the additional line will appear as duplicate and deny for that reason)

Pathology claim example billing 3 units of service for CPT code 88305 with modifier 26:

Correct: Bill one line with CPT code 88305-26 and 3 units.
Incorrect: Three lines with CPT code 88305-26 with 1 unit each for the same date of service (the additional lines will appear as duplicate and deny for that reason)

Radiology Services

When multiple radiological services described by a single CPT code are provided to a patient on one service day by the same provider, the provider should append the appropriate modifier to describe the circumstances.
Radiology claim **e**xample billing CPT code 76816 (ultrasound) for a multiple pregnancy:
Modifier 59 is used with CPT code 76816 when reporting an ultrasound of a pregnant uterus for each additional fetus in a multiple pregnancy. For example, in a twin pregnancy report 76816 and 76816-59. For triplets report 76816, 76816-59 and 76816-59.

For x-rays, unless the procedure described is inherently bilateral, append the correct modifier when multiple radiological services described by a single CPT code are provided to a patient on one service on one service day by the same provider:

Radiology claim example billing CPT code 73562 (radiological exam of the knee, three views):

When CPT code 73562 is performed on the left and right knee of the patient on the same service date by the same provider report CPT codes 73562-LT and 73562-RT.

Skilled Nursing Facility Claims

Resource Utilization Groups, version IV (RUG-IV)

For services furnished *prior to October 1, 2019*, submit your claim with a Resource Utilization Groups, version IV (RUG-IV) rate. RUG-IV consists of two case-mix adjusted components: Therapy: Based on volume of services provided, and Nursing. The nursing Case-Mix Index (CMI) under RUG-IV does not reflect specific variations in non-therapy ancillary (NTA) utilization. RUG-IV uses a constant per diem rate, meaning that the payment rate for each day of the SNF stay is the same per diem rate. The per diem rate that is applicable to the entire admission is required to be submitted on the claim form for processing.

Patient Driven Payment Model

For services furnished *on or after October 1, 2019*, submit your claim with Patient Driven Payment Model (PDPM) rates. CMS has finalized a new case-mix classification model, the Patient Driven Payment Model (PDPM), that, effective beginning October 1, 2019, will be used under the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) for classifying SNF patients in a covered Part A stay. PDPM consists of five case-mix adjusted components, all based on data-driven patient characteristics: Physical Therapy (PT), Occupational Therapy (OT), Speech Language Pathology (SLP), Nursing and NTA (non-therapy ancillary). PDPM utilizes a variable per diem adjustment factor, which adjusts the per diem payment over the course of the patient's stay. The variable per diem rates is required to be submitted on the claim form for processing.

Subacute Care Facility, Extended Care and Acute Rehabilitation Facility Services

Subacute care facilities, extended care and acute rehabilitation facility services require prior authorization. A sub-acute facility provides short term (several days to several months), medically necessary intensive and/or comprehensive rehabilitation services for a targeted population who have had an acute event as the result of an illness, injury, or exacerbation of a disease process. The level of care is more intensive than the traditional skilled nursing facility and less intensive than acute inpatient hospital care. In general, it provides a full spectrum of inpatient care designed as an alternative to acute hospitalization.

These services are billed on an institutional claim form and include usage of the following codes (not an all-inclusive list):

Discharge code 62 (acute hospital transfer to an inpatient rehab facility (IRF)

Revenue code 0128 – Rehabilitation (REHAB 2BED)

Revenue code 0118 – Rehabilitation (REHAB/PVT)

Revenue code 19X (sub-acute inpatient) requires bill type 17X
Bill type 14X represents Other Rehabilitation Facility (ORF)

Benefit – 100 days maximum. If a member is admitted as acute inpatient cost sharing applies, if a member is then transferred to acute rehab, new cost sharing starts from day one of the admission to the rehab bed.

Supplies
Submit supplies and materials using the appropriate HCPCS Level II code. Charges submitted with an unspecified CPT code (99070) will be denied. Routine office supplies such as band aids, swabs, alcohol pads, sanitary hand soap, syringes, needles, gowns, sterile gloves, and exam gloves are not a covered benefit. Equipment used multiple times for multiple patients is not separately billable or reimbursable. For example, thermometers, otoscopes, or oximetry monitors. Whenever a code is billed, which includes another service or supply the included service or supply is not eligible for separate reimbursement.

For flushes, diluents, saline and sterile water, per CPT and CMS guidelines, heparin flushes, saline flushes, IV flushes of any type and solutions used to dilute or administer substances, drugs or medications are included in the administration service. These items are considered inclusive to the procedure and are not eligible for separate reimbursement.

CPT code 99072 (Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease) is not payable for the Public Health Emergency declared for SARSCOV2 (COVID-19).

Supplies used for authorized durable medical equipment (DME) do not require approval after the DME is initially approved by the Plan. For example, after a continuous pressure airway pressure (CPAP) machine is purchased by the Plan and the associated supplies (e.g., face mask, tubing, and nasal pillows) needed for continued usage of the CPAP machine require replacement, providers may bill the supplies without requesting prior authorization.
Applicable Revenue Codes billable on the CMS-1450 form include:
0270X (Medical/Surgical Supplies and Devices)

0270 – General
0271 – Nonsterile
0272 – Sterile
0273 – Take-home supplies
0274 – Prosthetic/orthotic devices
0275 – Pacemaker
0276 – Intraocular lens
0277 – Take-home oxygen

0278 – Other implants
0279 – Other supplies/devices

Guidelines for processing payment for revenue codes (0270 – 0279):

- Take-home items are non-covered and will be denied when billed.
- Intraocular lenses are not separately payable, they are inclusive to the cataract procedure.
- When billed for outpatient services revenue codes 0274, 0275, 0278 and 0279 require a HCPCS or CPT code(s). Revenue code 0279 is generally non-covered.
- Generally, only revenue codes 0272, 0274, 0275 and 0278 may be eligible to be carved out and paid separately as specified within the Provider Agreement.

Revenue code 062x (Medical/Surgical Supplies – Extension of 027X)

0621 – Incident to Radiology (requires a radiological service revenue code to be reported on same claim submission)
0622 – Incident to Other Diagnostic Services (requires an other diagnostic services revenue code to be reported on same claim submission)
0623 – Surgical Dressings (used by home health care providers)
0624 – FDA investigational devices (investigational services are not covered by VCHCP)

Implants

For claims billed with implants the main surgery or procedure may require authorization. Supplies and implants are ancillary items. For contracted practitioners, the Provider Agreement will demonstrate if an invoice is required to process payment for carve-out items or if a dollar-limit threshold specifies eligibility for carve-outs. Implants are generally defined as an item for medical use implanted in the body such as a piece of tissue, prosthetic device, or another item/implant that is permanent. Some items that are implanted become biologically inert (are no longer useful) after a few months such as radioactive seeds used to treat prostate cancer. The FDA definition of an implant is a medical device or tissue that is placed inside or on the surface of the body. An implant is a device that is placed into a surgically or naturally formed cavity of the human body and is intended to remain there for a period of 30 days or more. However, there may be instances where a device that remains in the body less than 30 days could be considered an implant, such as implants which deliver medication, monitor body functions, or provide support to organs or tissues. An example of a device to provide support to tissue is a breast expander (C1789) when billed with CPT code 19357.

Examples of Surgical Supplies include but are not limited to:

- Catheters of any kind
- Guidewires
- Imaging coil, magnetic resonance (insertable)
- Introducer/sheath
- Probes

Examples of Implants include but are not limited to:

- Angio-seals (can be different materials – hard or soft)

- Breast prosthesis
- Closure devices
- Connective tissue (human or non-human, includes synthetic)
- Defibrillators (reportable under revenue code 0275)
- Event recorders
- Generator, neurostimulator
- Grafting materials such as bone (human or animal)
- Hydro pearls, seeds or pellets used for treatment of tumors.
- Infusion pump, programmable
- Joint devices (for hip or knee replacement)
- Leads, cardiac-related procedure(s)
- Mesh
- Pacemaker (reportable under revenue code 0275)
- Screws, anchors, plates
- Stents coated/covered, with delivery system.

All supplies and implants will be reviewed for determination of coverage; denial may be issued when:

- Revenue codes that require HCPCS codes are billed absent of HCPCS codes.
- Items billed are experimental and investigational.
- Claims are missing attachments such as itemized statements or invoices to establish eligibility for carve-out reimbursement as specified by the Provider Agreement.

Oral Appliances

Oral appliances may be covered as an alternative treatment for sleep apnea in certain situations, however prior authorization is required.

CPT Code for Sleep Apnea Custom Oral Appliance: E0486.

CPT Code 99459/Pelvic Examination Practice Expense

Pelvic examination practice expense CPT code 99459 is an active code in the Medicare Physician Fee Schedule. It is billed to cover the practice expense for performing a pelvic exam and is an add-on code that may only be reported with new and established patient visit codes 99202-99205, 99212-99215 and preventive medicine codes 99383-99397, 99393-99397. Although CPT guidelines also allow 99459 to be reported with consultation codes 99242-99245 these codes will not be accepted by the Plan when billed by providers with Medicare reimbursement agreements since consultation codes are no longer used by CMS.

Suture Removal

Per CMS suture removal is part of a minor surgical procedure's global package. For suture removal the Plan follows these guidelines: If the same physician who placed the sutures removes them during the original procedure's global period the removal cannot be reported separately, however, removal of sutures by a physician other than the physician who originally closed the wound may be reported under S0630. For example,

if sutures that are placed in an urgent care are subsequently removed in the office of the member's primary care practitioner S0630 may be reported.

Surgical Trays

When billing for a surgical tray, providers will need to bill HCPCS Level II Code A4550. Surgical tray benefits will only be considered when billed in conjunction with any surgical procedure for which use of a surgical tray is appropriate, when the procedure is performed in a physician's office rather than a separate surgical facility.

Temporary (G) Codes Assigned by CMS on a Temporary Basis to Identify Procedures/Services

The Plan does not have a benefit for codes used for performance measures. Emerging technology services and procedures require physician review for medical necessity. Temporary codes for services that are accepted medical practice and widely performed and reimbursed by the Medicare Physician Fee Schedule are covered.

Unlisted Codes

Unlisted codes (or miscellaneous CPT codes) need to be submitted with a clear and specific description for the item or service being billed on the claim form. For the CMS 1500 form please use field 19 for remarks. Medical records are required for review.

Submit an attachment with the claim including the following information:

- An explanation that indicates what the service consisted of
- Highlight the portion of the medical record pertaining to the unlisted service being billed.
- Provide a comparative CPT code to the unlisted service and include an explanation why it is a comparative service.

Unlisted, Not Otherwise Classified or Specified and Miscellaneous Codes need to be submitted with a clear and specific description for the item or service being billed. Authorization is required. Medical records may be requested for review. These codes include but are not limited to: 15999, 17999, 19499, 20999, 21089, 21299, 21499, 21899, 22899, 22999, 23929, 24999, 25999, 26989, 27299, 27599, 27899, 28899, 29799, 29999, 30999, 31299, 31599, 31899, 32999, 33999, 36299, 37501, 37799, 38129, 38589, 38999, 39499, 39599, 40799, 40899, 41599, 41899, 42299, 42699, 42999, 43289, 43499, 43659, 43999, 44238, 44799, 44899, 44979, 45399, 45499, 45999, 46999, 47379, 47379, 47399, 47579, 47999, 48999, 49329, 49659, 49999, 50549, 50949, 51999, 53899, 54699, 55559, 55899, 58578, 58579, 58679, 58999, 59897, 59898, 59899, 60659, 60699, 67299, 67399, 67599, 67999, 68399, 68899, 69399, 69799, 69949, 69979, 76496, 76497, 76498, 76499, 76999, 77299,77399, 77499, 77799, 78099, 78199, 78299, 78399, 78499, 78599, 78699, 78799, 78999, 79999, 81479, 81599, 84999, 85999, 86486, 86849, 86999, 87999, 88099, 88199, 88299, 88399, 88749, 89240, 89398, 90399, 90749, 90899, 90999, 91299, 92499, 92499, 92700, 93799, 93998, 94799, 95199, 95999, 96379, 96549, 96379, 96549, 96999, 97039, 97139, 97799, 99199, 99600, A0999, A4335, A4421, A9999, B9998, B9999, E1399, E1699, J8597, J8999, J9999, L2999, L3999, L5999, L7499, L8049, L8499, L8698, and L8699. Some items or services may be non-covered.

Unclassified J codes require a description and applicable NDC code: J3490 Unclassified drugs, J3590 Unclassified biologics, J3591 Unclassified drug or biological used for ESRD on dialysis.

State Medicaid Agency Codes/Medi-Cal Codes

HCPCS code range T1000-T5999 (National Codes) were established for State Medicaid Agencies and contain codes for such services as independent nursing service and nursing assessment. In general, VCHCP does not accept Medicaid (Medi-Cal) codes unless otherwise specified in a provider's agreement. Claims containing HCPCS codes T1000 – T5999 and Medi-Cal codes such as Z7500 (use of treatment room) and Z7502 (use of emergency room) will be denied as non-covered invalid codes.

Miscellaneous Services

Specimen handling and/or conveyance of specimen for transfer from the office to a laboratory is not covered (CPT codes 99000, 99001).

If patients are evaluated for the need for COVID-19 testing and a specimen is collected onsite bill appropriate E/M code. CPT code 99211 was approved for specimen collection in an outpatient setting (e.g., physician office, outpatient hospital, urgent care).

The following codes are not payable for contracted providers but will be reviewed on a case-by-case basis for non-contracted providers. Additional information may be required.

- CPT code 99050 (Service(s) provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday, or Sunday), in addition to basic services).
- CPT code 99051 (Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service).
- CPT code 99053 (Service(s) provided between 10:00PM and 8:00AM at 24-hour facility, in addition to basic service).
- CPT code 99056 (Service(s) typically provided in the office, provided out of the office at the request of patient, in addition to basic service).
- CPT code 99058 (Service(s) provided on an emergency basis in the office, which disrupts other scheduled services, in addition to basic service).
- CPT code 99060 (Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service.

CPT Category II codes used for supplemental tracking for performance measurements to facilitate data collection about quality of care are not required by the Plan and may not be used as a substitute for Category I CPT codes. These codes will be denied because they are not separately payable.

CPT Category III codes are a set of temporary (T) codes assigned to emerging technologies, services, and procedures. These services require medical necessity review.

When a Category III code is covered, it may be assigned reimbursement on a case-by-case basis as allowed per the provider's Service Agreement or through a case agreement.

Revenue Code 0761 (Use of a Treatment Room When a Procedure or Treatment Has Been Performed)

Per the National Uniform Billing Committee's UB-04 Manual, revenue code 0761 should only be used when a specific procedure has been performed or treatment has been rendered. Evaluation & management services (CPT/HCPCS codes 99202-99215, 99241-99245 or G0463) reported with revenue code 0761will be denied for invalid code combination.

Non-Covered Services

An example of non-covered services that will be denied if billed includes but is not limited to:

- Alternative birthing center or home delivery.
- Alternative Care Services such as hypnotherapy, sleep therapy and homeopathic medicine.
- Cosmetic surgery, when primarily performed to alter or reshape normal structures of the body to improve appearance, is not medically necessary.
- Dental services, except when dental examinations and treatment of gingival tissues are performed for the diagnosis or treatment of a tumor, or when immediate emergency care to sound natural teeth as a result of an accidental injury is required.
- Disposable supplies for home use that are available over the counter such as dressing, surgical or incontinence supplies.
- Hearing aids; including furnishing, fitting, installation, or replacement.
- Work-related illnesses or injuries (workers compensation) or services provided or arranged by another governmental agency.

Diagnostic Code (ICD-10-CM) Rules

External cause of morbidity codes (ICD-10 code range V00-Y99) used to describe how an injury or health condition occurred should not be used as the primary diagnosis but should be sequenced after the appropriate injury code.

Manifestation codes describe the manifestation of an underlying disease, not the disease itself. Per the ICD-10-CM Manual instructions for the use of manifestation codes include (1) Do not report a manifestation code as the only diagnosis, (2) Do not report a manifestation code as a first-listed or principal diagnosis, and (3) Code the underlying disease first.

Secondary diagnosis codes can only be used as a secondary diagnosis. Since these codes are only for use as supplemental codes, any procedure or service received with a secondary diagnosis code as the principal or primary diagnosis will be denied as incorrectly coded. A secondary diagnosis is a condition that a patient has in addition to their primary diagnosis, e.g., if a patient has high blood pressure but is admitted to the hospital for pneumonia, high blood pressure is the secondary diagnosis.

Sequela codes in ICD-10-CM are used to report conditions that develop as a result of an injury or illness cannot be the primary diagnosis on a claim, nor can it be the only diagnosis. The seventh character in the code is always an "S" to indicate that the condition is a late effect that occurred after the initial injury or illness. Examples include joint contracture after a tendon injury, hemiplegia after a stroke or scar formation following a burn.

Examination and encounter for administrative purpose:
Claims billed with codes which describe an encounter or administrative examination within diagnostic code range Z02.0-Z02.9 that do not contain an accompanying diagnosis code for symptom or illness will be denied and medical records requested where additional information is needed to make a determination for coverage. Patient encounters for the sole purpose of pre-employment examination, obtaining a driver's license, issuance of medical certification, school admittance, military recruitment and sports clearance are examples of non-covered services when billed without other codes describing illness or symptoms.

Diagnostic Code Range Z02.0-Z02.9	Description
Z02.0	Encounter for examination for admission to educational institution
Z02.1	Encounter for pre-employment examination
Z02.2	Encounter for examination for admission to residential institution
Z02.3	Encounter for examination for recruitment to armed forces
Z02.4	Encounter for examination for driving license
Z02.5	Encounter for examination for participation in sport
Z02.6	Encounter for examination for insurance purposes
Z02.7	Encounter for issue of medical certificate
Z02.71	Encounter for disability determination
Z02.79	Encounter for issue of medical certificate
Z02.8	Encounter for other administrative examinations
Z02.81	Encounter for paternity testing
Z02.82	Encounter for adoption services
Z02.83	Encounter for blood-alcohol and blood-drug test
Z02.89	Encounter for other administrative examinations
	Encounter for examination for admission to prison
	Encounter for examination for admission to summer camp
	Encounter for immigration examination
	Encounter for naturalization examination
	Encounter for premarital examination
Z02.9	Encounter for administrative examinations, unspecified

Corrected Claims

A corrected claim needs to be submitted when a revision to coding, service dates, billed amount, or member information is required. Contracted providers must submit corrected claims within the timely filing days allowed for submission (from the Plan's last claim determination date related to the claim information requiring revision) as specified within

their contract. Non- contracted providers are allowed 180 days from the Plan's last claim determination date for timely submission of corrected claims.

Examples of a Corrected Claim: Any changes made to the original claim involving missing or invalid charges or units, invalid or missing modifiers or CPT, HCPCS or Revenue codes, or missing or invalid member information.

Rejection Claims

Paper claims are most often rejected by the Plan due to containing incorrect or invalid information that does not match what's on file in the claim processing system regarding member eligibility. A claim can also be rejected because it is missing detail required for processing such as diagnostic or CPT codes, has a mismatched total amount or contains misdirected behavioral health services which require forwarding for processing. Rejected paper claims that are returned to a provider's office are not processed because they are never entered into the claims system. An appeal is not necessary. To resubmit the rejected claim simply correct it and return for processing (include remarks such as "*corrected claim submission*" in box 19 on the 1500 claim form or field 80 on the UB 04 claim form). Do not write elsewhere on the claim form.

Electronically received claims accepted into the claims processing system are denied by the Plan with an applicable message such as "*invalid CPT code for service date*." Simply correct the claims and resubmit with the appropriate frequency code or bill type as applicable to form type.

Misdirected behavioral health claims received electronically are an exception, they are rejected by the Plan with a message explaining the reason for rejection and forwarded to Optum Behavioral Health Services/Life Strategies for processing.

Providers can submit eligible behavioral health service claims to Optum Behavioral Health Services (OBHS)/Life Strategies, PO BOX 30602, SALT LAKE CITY, UT 84130/800-851-7407 for processing. For questions, contact OBHS at 800-851-7407.

Telehealth/Telemedicine

Telehealth and telemedicine are defined as the use of technology such as computers and mobile devices to access health care services, manage health care remotely or provide patient education, as it allows patients and health care providers to communicate by video, phone, or email. Telehealth is different from telemedicine because it refers to a much broader scope of remote health care services than telemedicine. Telehealth can refer to remote *non-clinical* services (such as patient education and public health communication) while telemedicine refers specifically to remote *clinical* services like diagnosis and treatment, remote analysis and monitoring, and electronic data storage such as an ECG and glucose levels).

Per California Health & Safety Code section 1374.14 health plan contracts starting or renewed on or after January 1, 2021, are required to process telehealth/telemedicine services as follows:

- Under health plan participation agreements, the plan "shall reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of

an enrollee or subscriber appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment."

- Health plans and providers can continue to negotiate reimbursement rates under their participation agreements. However, services that are the same, as determined by the provider's description of the service on the claim, must be reimbursed at the same rate whether provided in-person or through telehealth.
- A health plan may charge a deductible, copayment or coinsurance for a health care service delivered via telemedicine if it does not exceed the deductible, copayment or coinsurance applicable to a service delivered via in-person consultation or contact.

The Plan, in abidance with California Health & Safety Code Section 1374.14, reimburses providers the same amount regardless of whether the service was provided in-person or remotely. Likewise, member cost sharing (deductibles, copayments, or coinsurance) is the same whether care was provided in-person or remotely. Authorization is required only when applicable if the service was performed in-person. The information contained within this section is for general guidance only, for inquiries related to coverage of a specific service or billing code please contact the Plan.

Billing Guidelines for Telehealth/Telemedicine for the CMS 1500 Claim Form

Audio and Visual Services
- Place of service code "02" or "10" to indicate Telehealth place of service
- The appropriate CPT/HCPCS code
- The applicable Telehealth/Telemedicine modifier related to the service

Audio
- Place of service code "02" or "10" to indicate Telehealth place of service
- The appropriate CPT/HCPCS code for covered services listed in CPT Appendix T and codes 99441, 99442 and 99443 through service date 12/31/2024
- Modifier 93 or FQ

Asynchronous
- Place of service code "02" or "10" to indicate Telehealth place of service
- The appropriate CPT/HCPCS code
- Modifier GQ

Store and Forward
- Place of service appropriate to the location of the billing provider
- The appropriate interprofessional CPT/HCPCS code
- Modifier GQ

Remote Patient Monitoring
- Place of service code appropriate to the location of the billing provider

- The appropriate CPT/HCPCS code

Professional Claim Form Instructions:

- Box 24B: Use Place of service (POS) code **02** (Location where health services and health related services are provided or received through a telecommunications system other than a patient's home). Effective 1/1/2022 if the patient receives telehealth in their home use POS code 10. Claims billed with invalid modifiers and POS code combinations such as modifier 95 and POS code 11 will be denied.
- Include a Modifier in box 24D:

  Modifier 95: Synchronous telemedicine service rendered via a real-time interactive telecommunications system.
  Modifier GT: Via interactive audio and video telecommunications systems.
  Modifier GQ: Via asynchronous telecommunications systems.
  Modifier 93: Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system (the American Medical Association, CPT Appendix T contains a list of eligible codes; VCHCP will accept this modifier when appended to covered CPT/HCPCS codes.
  Modifier FQ: A telehealth service was furnished using real-time audio-only communication technology.

Definitions and Service Examples for Synchronous or Asynchronous Telecommunication

- Synchronous telecommunication is the exchange of information between two people in real time. The telephone is an example of synchronous communication.
- Asynchronous telecommunication is the exchange of ~~date~~ data between two or more parties without the requirement for all recipients to respond immediately. Email is an example of asynchronous telecommunication.
- Store and forward is the transmission of a member's medical information from an originating site to the physician or practitioner at the distant site. The physician or practitioner can review the medical case without the member being present.
- Remote patient monitoring/remote physiologic monitoring is treatment management services provided by medical professionals to manage a patient under a specific treatment plan via live interactive communication or store and forward through a medical device defined by the FDA and ordered by a physician or other qualified QHCP.

Telehealth/telemedicine services identified by the American Medical Association's Current Procedural Terminology (CPT) coding system that are acceptable to be used to report telemedicine services when appended by modifier 95 include but are not limited to:

99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99231, 99232, 99233, 99308, 99309, 99310 99406, 99407, 99417, 99418, 99495, 99496, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 92507, 92508, 92227, 92228, 92521, 92522, 92523, 92524, 92526, 93228, 93229,

93268, 93270, 93271, 93272, 96105, 96125, 96160, 96161, 97082, 97803, 97161, 97162, 97165, 97166, 97110, 97112, 97116, 97530, and 97535. (Codes 99354, 99355, 99457, 99458, 97804, 93298 and 96040 are deleted from the list on 12/31/2024).

Effective for calendar year 2025, the list will be updated to include the following additional codes used to report synchronous (real-time) telemedicine services when appended by modifier 95; these procedures involve electronic interactive tele-communications equipment that include both audio and video.

Additional CPT codes that are acceptable to be used to report telemedicine services when appended by modifier 95 (only if approved for usage within your provider services agreement or otherwise authorized) include:

99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255

(CPT code 99241 was deleted on 12/31/2022)

Telehealth/telemedicine procedures and professional services identified by the Health Care Procedure Coding System (HCPCS) that are acceptable to be used for reporting when appended with appropriate telehealth/telemedicine modifiers include:

G0425, G0426, G0427, G0508, G0509, G2010, G2012, G2061, G2062, G2063 (Note: HCPCS G2061, G2062 and G2063 were terminated effective 12/31/2020).

For service dates 04/01/2022 through 12/31/24 the Plan accepts CPT codes 99441-99443 for synchronous telemedicine services rendered via telephone or other real-time interactive audio-only telecommunications system as defined below:

99441: Telephone E/M service; 5-10 minutes of medical discussion
99442: 11-20 minutes of medical discussion
99443: 21-30 minutes of medical discussion

The above codes may be billed with modifier -93 or -FQ.

The Plan does not cover fees for “originating site for reimbursement related to the use of a room and telecommunication equipment” such as those billed under HCPCS code Q3014, a Medicare temporary code is used for Medicare beneficiaries when a provider is hosting a patient in the office while communicating with another provider remotely.

Non-covered:

- Non-direct patient services other than remote patient monitoring
- Services that require equipment and/or direct physical hands-on care that cannot be provided remotely
- Services that are not eligible for reimbursement when rendered to the patient

Due to the COVID-19 pandemic (caused by the coronavirus SARS-Co V-2) and under declaration of a Public Health Emergency (PHE) VCHCP covers some services not typically provided via telehealth and telemedicine. A comprehensive list of these

temporarily covered services is maintained separately by VCHCP. Services not typically allowed to be performed via telehealth and telemedicine will no longer be covered by VCHCP once the COVID-19 PHE has ended.

2025 Telemedicine Changes

Effective January 1, 2025, in the Evaluation and Management (E/M) section there are 17 new telemedicine codes with CPT code range 98000-98016 (please refer to your contract and the guidelines below for usage) – As a reminder; telephone E/M codes (99441-99443) are deleted; CPT codes 99441-99443 will not be accepted by the Plan for service dates after 12/31/2024.

Under current Medicare guidelines CPT codes 98000 – 98015 are not valid. Therefore, the Plan effective January 1, 2025, will accept CPT codes 99202-99215 with modifier 95 (audio-visual) or modifier 93 (audio-only) as applicable to the services rendered. Please note the "replacement codes" designated for CPT codes 98000 – 98015:

Invalid for Medicare	Replacement Code
98000	99202
98001	99203
98002	99204
98003	99205
98004	99212
98005	99213
98006	99214
98007	99215
98008	99202
98009	99203
98010	99204
98011	99205
98012	99212
98013	99213
98014	99214
98015	99215

For the above-mentioned services the Plan accepts the following place of service (POS) codes:

- POS 02 refers to telehealth provided other than in the patient's home
- POS 10 refers to telehealth provided in patient's home.

Note: If place of service code 11 is billed for telehealth the claim will deny for "Invalid place of service code for modifier". A corrected claim will be required.

Also, newly effective as of January 1, 2025 is CPT code 98016 (Brief communication technology-based service): For synchronous audio-only evaluation and management lasting for 5-10 minutes, you may report 98016 (Brief communication technology-based service (e.g., virtual check-in)) by a physician or other qualified health care practitioner who can report evaluation and management services provided to an established patient, 5-10 minutes of medical discussion. The service must not have originated from a related evaluation and management service provided within the previous 7 days nor led to an evaluation and management service or procedure within the next 24 hours or soonest available appointment. This brief virtual check-in code will replace the existing HCPCS code G2012.
Prolonged Service Add-on Code 99417 for Codes 98003, 98007, 98011 and 98015

For the highest-level synchronous audio-video and audio only evaluation and management services (98003, 98007, 98011 and 98015) you may use existing prolonged service add-on code +99417 (Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time).

Claims Processing: Preventive Care or Diagnostic Care

Diagnostic care is generally services providers perform to look for a specific illness or disease. The Plan may apply cost sharing for these services.

Preventive care helps to detect or prevent serious diseases and medical problems. This may also be called routine care. Examples of preventive care include annual well patient examinations, immunizations, screening mammography and screening colonoscopy. The Plan does not apply cost sharing for these services. Modifier 33 may be applied by providers to preventive service codes to indicate that the service is one that waives a patient's copayment, deductible, and co-insurance. However, modifier 33 does not have to be appended to codes which describe services that are inherently preventive, such as screening mammography.

Well patient examinations (periodic comprehensive preventive medicine evaluation/re-evaluation) require appropriate CPT and diagnostic codes. Claims billed with invalid code combinations will be denied. The Plan does not accept Medicare well visit codes G0402, G0438 and G0439. The appropriate CPT codes for periodic comprehensive preventive medicine evaluation/re-evaluation include 99381-99387 (new patient) and 99391-99397 for established patients.

Examples of correct coding for routine child and general adult examinations:

Age	CPT code	ICD-10-CM Codes
1-4 years	99382 (new patient)	Z00.121 Routine child exam w/abnormal findings Z00.129 Routine child exam without abnormal findings

40-64 years	99386 (new patient)	Z00.00	General adult exam without abnormal findings
		Z00.01	General adult exam with abnormal findings

Preventive Healthcare Services

Preventive health care services include screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. No cost sharing or authorization is applicable when performed in-network unless the service is rendered emergently or otherwise covered such as with genetic disorder testing provided by the Alpha Feto Protein (AFP) program of the State Department of Health Services**.**

Summary of Preventive or Sexual/Reproductive Health Care Services Covered by Ventura County Health Care Plan without Cost Share:

- Comprehensive prenatal care provided by a physician during pregnancy including diagnosis of genetic disorders of the fetus in cases of high-risk pregnancy and participation in the Expanded Alpha Feto Protein (AFP) program of the State Department of Health Services and antepartum screening for maternal mental health conditions such as depression.
- Postpartum care including screening for maternal mental health conditions such as depression.
- Preventive care, health screenings including cervical and colorectal cancer, immunization.
- Routine physical examination (periodic medicine evaluation)/Well child visits
- Birth control, vasectomies, emergency contraceptive services, pregnancy tests, abortion, and abortion-related services.
- Screening/prevention/testing/diagnosis/treatment of sexually transmitted diseases and infections, including home test kits (coverage effective 1/1/22 per SB 306).
- The diagnosis and treatment of sexual assault or rape, including the collection of medical evidence regarding the alleged rape or assault.
- Screening/prevention/testing/diagnosis/treatment of the human immunodeficiency virus (HIV).

Preventive Care Recommendation Resources for Plan Coverage and Claims Processing

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force (USPSTF) as periodically updated.
2. Immunizations that have in effect a recommendation, as periodically updated, from the Advisory Committee on Immunization Practices (ACIP) of the federal Centers for Disease Control and Prevention with respect to the individual involved.
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided in the comprehensive guidelines, as periodically updated, supported by the United States Health Resources and Services Administration (HRSA)/ACA.

4. With respect to women, those additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration (HRSA)/ACA.

Adverse Childhood Experiences (ACE) Screening

California enacted SB-428 to expand health insurance coverage for Adverse Childhood Experiences screening. It applies to all health care service plan contracts that provide coverage for pediatric services and preventive care. ACEs are traumatic childhood experiences.

Screening Frequency:

Children and adolescents under age 21: Permitted for periodic ACE rescreening as determined appropriate and medically necessary, not more than one per year, per clinician (per managed care plan). Children should be screened periodically to monitor the possible accumulation of ACEs and increased risk for a toxic stress physiology.

Adults aged 21 through age 64: Permitted once in their adult lifetime (through age 64), per clinician (per managed care plan). Screenings completed while the person is under age 21 do not count toward the one screening allowed in their adult lifetime. Adults should be screened at least once in adulthood.

Providers must be certified to perform the screenings and contracted with VCHCP.

Applicable HCPCS codes: G9919 (Screening performed, patient is at high risk for toxic stress and G9920 (Screening performed, patient is at lower risk for toxic stress).

No cost share or authorization requirements are applicable to ACE screening.

Adult Periodic Health Examination and Preventive Services

For adults, periodic health examinations include all routine diagnostic testing and laboratory services appropriate for such examinations. This includes coverage for cancer screening tests including prostate-specific antigen testing and rectal examination for the diagnosis of prostate cancer, mammograms, and cervical cancer screening tests. Coverage for a cervical cancer screening shall include the conventional Pap test, and FDA-approved human papilloma virus (HPV) screening test and cervical cancer screening tests. The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the member including: a member's desire for physical examinations; reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance. Per USPSTF recommendation, clinicians shall provide tobacco use counseling and interventions for non-pregnant adults. Clinicians shall ask all adults about tobacco use and provide tobacco use counseling for those who use tobacco products. Additional interventions include pregnant women; clinicians shall ask all pregnant women about tobacco use and provide augmented, pregnancy tailored counseling to those who smoke.

Preventive Services for Adults include:

- Abdominal aortic aneurysm one-time screening (for men of specific ages who have ever smoked
- Alcohol misuse screening and counseling
- Aspirin use
- Blood pressure screening
- Cholesterol screening
- Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese
- Diet counseling
- Falls prevention (for adults 65 years and over)
- Hepatitis B screening
- Hepatitis C screening
- HIV screening, for everyone age 15 to 65, and other ages at increased risk
- PrEP (pre-exposure prophylaxis) HIV medication

- Immunizations for adults:
  - Chickenpox (Varicella)
  - Diphteria
  - Flu (influenza)
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus (HPV)
  - Measles
  - Meningococcal
  - Mumps
  - Whooping Cough (Pertussis)
  - Pneumococcal
  - Rubella
  - Shingles
  - Tetanus

- Lung cancer screening (for adults 50 to 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
- Obesity screening and counseling
- Sexually transmitted infection (STI) prevention counseling
- Statin preventive medication
- Syphilis screening
- Tobacco use screening
- Tuberculosis screening

Preventive Services Specific to Women Include:

- Breastfeeding support and counseling
- Birth control (FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling as prescribed by a health care provider for women with reproductive capacity

- Folic acid supplements for women who may become pregnant.
- Gestational diabetes screening for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes.
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening
- Maternal depression screening for mothers at well-baby visits
- Preeclampsia screening for pregnant women with high blood pressure
- Rh incompatibility screening for all pregnant women and follow up for women at higher risk.
- Syphilis screening
- Expanded tobacco intervention and counseling for pregnant tobacco users.
- Urinary tract or other infection screening
- Bone density screening for women over age 65 or women who have gone through menopause (see separate section for guidelines for DEXA scan)
- Breast cancer mammography screening (effective in 2023 breast cancer screening at age 40 every two years for women).
- Cervical cancer screening
- Chlamydia infection screening
- Diabetes screening
- Domestic and interpersonal violence screening and counseling for all women
- Gonorrhea screening
- HIV screening and counseling for everyone age 15 to 65, and other ages at increased risk
- PrEP (pre-exposure prophylaxis) HIV prevention medication
- Sexually transmitted infections counseling
- Tobacco use screening and interventions
- Urinary incontinence screening for women yearly
- Well-women visits to get recommended services for all women

Diagnoses for adult periodic medical examination include:

- Z00.00 – Encounter for general adult medical examination without abnormal findings
- Z00.01 – Encounter for general adult medical examination with abnormal findings

Child, Infant, and Adolescent Examination and Preventive Services

For preventive health purposes, a periodic health evaluation and diagnostic preventive procedures are covered, based on "A" and "B" rating recommendations published by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the Health Resources and Services Administration, as well as generally medically accepted cancer screening tests. Coverage includes all routine diagnostic testing and laboratory services appropriate for periodic health examinations consistent with the most current recommendations for preventive pediatric health care as adopted by the American Academy of Pediatrics and the most current version of the recommended childhood immunization schedule/United States adopted by the Advisory Committee on Immunization Practices (ACIP). For

persons through the age of 16, this includes vision and hearing testing to screen for deficiencies. This does not apply to refraction exams. The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the member, such as a member's desire for physical examinations, reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance. As recommended by U.S. Preventive Services Task Force (USPSTF), clinicians shall provide tobacco use intervention for child and adolescents, including education and brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

The U.S. Preventive Services Task Force "A" and "B" rated service, Advisory Committee Immunization Practices (ACIP) and U.S. Health Resources and Services Administration (HRSA)/Affordable Care Act (ACA) recommendations are used by VCHCP to establish guidance for claims processing.

Covered screenings and other services include:

- Alcohol, tobacco, and drug use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years and 15 to 17 years
- Bilirubin concentration screening for newborns
- Blood pressure screening for children: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Blood screening for newborns
- Depression screening for adolescents begins routinely at age 12
- Developmental screening for children under age 3
- Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders
- Fluoride supplements for children without fluoride in their water source
- Fluoride varnish for all infants and children as soon as teeth are present
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns; and regular screenings for children and adolescents as recommended by their provider
- Height, weight and body mass index (BMI) measurements taken regularly for all children
- Hematocrit or hemoglobin screening for all children
- Hemoglobinopathies or sickle cell screening for newborns
- Hepatitis B screening for adolescents at higher risk
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use
- Immunizations for children from birth to age 18 – doses, recommended ages, and recommended populations vary:
    - Chickenpox (Varicella)

- Diphtheria, tetanus, and pertussis (DTaP
- Hemophilus influenza type B
- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Inactivated Poliovirus
- Influenza (flu shot)
- Measles
- Meningococcal
- Mumps
- Pneumococcal
- Rubella
- Rotavirus

Additional Covered Services:

- Lead screening for children at risk for exposure
- Obesity screening and counseling
- Oral health risk assessment for young children from 6 months to 6 years
- Phenylketonuria (PKU) screening for newborns
- Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk.
- Tuberculin testing for children at higher risk of tuberculosis: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Vision screening for all children
- Well baby and well-child visits (billed under CPT code range 99381-99385 (new patient) and 99391-99395 (established patient). Reportable diagnoses include Z00. 129: Encounter for routine child health examination without abnormal findings.

Preventive Screenings Billed with an Evaluation & Management Service

All screening and testing services can be billed with any evaluation & management (E/M) service, whether it be a well or a sick visit E/M under the appropriate circumstances.

Increased Frequency of Visits – Well Baby Checks

The American Academy of Pediatrics (AAP) recommends babies get checkups at birth, 3 to 5 days after birth and then at 1, 2, 4, 6, 9, 12, 15, 18 and 24 months. After a newborn is discharged from the hospital, they should only have one well-check visit with the pediatrician prior to the age of 1 month. If there is an additional visit performed after the 3 to 5 days after birth visit prior to the 1 month visit with a well-check diagnosis and a periodic medicine evaluation code it will be denied for “increased frequency of visits”.

Diagnostic Codes billable for newborn examination include:

Z00.110 – Health examination for newborn under 8 days old.
Z00.111 – Health examination for newborn 8-28 days.

Other diagnosis codes for pediatric well-check visits

The ICD-10 code for a well-child exam with normal findings is Z00.129. This code is used for routine health examinations for children and adolescents (0-17 years old) where no abnormal findings are identified.
Z00.121 is the ICD-10-CM diagnosis code for a routine child health exam with abnormal findings for children ages 0–17.

Additional Information: Increased Frequency of Visits – Periodic Health Examination for Children and Adults

For periodic health examination the frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the member including: a member's desire for physical examinations; for example, encounters for administrative exams, reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, court-ordered services, or a school sports or summer camp clearance.

Coverage For Children: periodic health examinations, including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current Recommendations for Preventative Pediatric Health Care, as adopted by the American Academy of Pediatrics; and the most current version of the Recommended Childhood Immunization Schedule/United States adopted by the Advisory Committee on Immunization Practices (ACIP). This includes vision and hearing testing to screen for deficiencies. This does not apply to refraction exams. The Plan shall provide coverage for the human papillomavirus vaccine (HPV) for enrollees for whom the vaccine is approved by the FDA. As recommended by U.S. Preventive Services Task Force (USPSTF) clinicians shall provide tobacco use interventions for: children and adolescents, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

Coverage For Adults: Periodic health examinations including all routine diagnostic testing and laboratory services appropriate for such examinations per the recommendations of the USPSTF, HRSA/ACA and ACIP.

Billing Colonoscopy Services

Colorectal Cancer Screening - Preventive

Preventive (screening) colonoscopy is reported for patients age 45 years and older with no abnormal signs or symptoms. An example claim would include reportable procedures and diagnoses, such as:

CPT code 45380: Colonoscopy, flexible; with biopsy, single and multiple
ICD-10 Diagnosis Z12.11: Encounter for screening for malignant neoplasm of colon

Colorectal Cancer Screening – Diagnostic

Diagnostic (screening) colonoscopy is reported for patients under age 45 or any age when the patient has abnormal signs and symptoms. Even if a patient qualifies for a screening it cannot be coded if they have symptoms. An example claim for a 43-year-old patient with symptoms of diarrhea and fecal abnormalities undergoing colonoscopy would include reportable procedures and diagnoses, such as:

CPT code 45380: Colonoscopy, flexible; with biopsy, single or multiple
ICD-10 Diagnosis code R19.5: Other fecal abnormalities
ICD-10 Diagnosis code R19.7: Diarrhea, unspecified

Usage of Modifier 33 for Colonoscopy

When a screening colonoscopy converts to a diagnostic or therapeutic procedure the surgeon should append modifier 33 to alert that the intent of the procedure was preventive screening to have the claim processed without cost sharing.

Claim example, Modifier 33: A 47-year-old patient has an abnormal finding of a polyp during their screening colonoscopy. The surgeon removes a polyp with a snare technique. Reportable procedure and diagnostic codes in this example include:

- 45385-33, Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesions by snare technique
- Z12.11, Encounter for screening for malignant neoplasm of colon
- K63.5, Polyp of the colon

DEXA Scans

DEXA is a bone density scan that uses low dose x-rays to see how dense (or strong) your bones are (it is also called a DEXA scan) – It is often used to diagnose or assess the risk of osteoporosis. Screening DEXA has no cost share.

Screening DEXA scan is recommended as follows:

- For people at average risk, women starting at age 65 and men at age 70.
- For people with one or more family members have had osteoporosis or more than one fracture causing a higher risk for bone loss.

Diagnosis: Z01.80 (osteoporosis bone density screening)

CPT code: 77080 (bone density scan of axial bones like hip, pelvis and spine).

Note: Diagnostic DEXA requires prior authorization and has a cost share.

Family Planning Services

The following family planning services are covered without cost share to the member:

All drugs, devices and other products for women as approved by the FDA and as prescribed by the member's provider, including but not limited to:

- IUD copper, IUD with progestin
- Shots/injections
- Oral contraceptives including combined pills, progestin only pills and extended/continuous use pills
- Patches
- Devices including vaginal contraceptive rings, diaphragms, sponges, cervical caps, Female condoms
- Spermicide
- Emergency contraception
- Patient education and counseling on contraception.

Covered family planning CPT/HCPCS codes (not an all-inclusive list) includes:

11976 – Removal, implantable contraceptive capsules
11981 – Insertion, drug delivery implant
11982 – Removal, non-biodegradable drug delivery implant
55250 – Vasectomy, unilateral or bilateral
57170 – Diaphragm or cervical cap fitting with instructions
58301 – Removal of intrauterine device (IUD)
58600 – Ligation or transection of fallopian tube(s), abdominal or vaginal approach
58605 – Ligation or transection of fallopian tube(s), abdominal or vaginal, postpartum
58611 – (Add on code) Ligation or transection of fallopian tube(s) when done at the time of c-section delivery or intra-abdominal surgery
58615 – Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring)
A4261 – Cervical cap for contraceptive use
A4264 – Permanent implantable contraceptive intratubal occlusion device and delivery system
A4266 – Diaphragm for contraceptive use
A4267 – Contraceptive supply, condom, male
A4268 – Contraceptive supply, condom, female
A4269 – Contraceptive supply, spermicide (e.g., foam or gel)
J1050 – Injection, medroxyprogesterone acetate, 1 mg (submit accurate units for dosage administered
J7296 – Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5mg
J7297 – Levonorgestrel-releasing intrauterine contraceptive system (Liletta), 52mg
J7298 – Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52mg.
J7300 – Intrauterine copper contraceptive
J7303 – Contraceptive supply, hormone containing vaginal ring.
J7304 – Contraceptive supply, hormone containing patch.
J7306 – Levonorgestrel (contraceptive) implant system, including implants and supplies.
J7307 – Etonogestrel (contraceptive) implant system, including implants and supplies.

Family Planning - Sterilization Services

Sterilization is defined as any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing. Family planning services such as sterilization (e.g., vasectomy, ligation of oviducts) do not require authorization. Cost sharing does not apply. Reportable ICD-10 Diagnosis: Z30.2; Encounter for sterilization.

Fluoride Chemoprevention

The Plan covers fluoride chemoprevention (application of topical fluoride varnish) as follows:

- The service is provided by the member's primary care physician (it is not covered when provided by a dentist).
- The patient is a child between the ages of 0-5 years.
- It is covered up to three (3) times per year.
- It is payable when billed with CPT code 99188.

Tobacco Use Screening and Cessation Intervention

The plan covers screening for all adults and adolescents and cessation interventions for adult and adolescent tobacco users (and expanded counseling for pregnant women) when performed by the member's primary care physician.
Applicable CPT/HCPCS Codes

99406 – Smoking and tobacco use cessation counseling, 3-10 minutes
99407 – Smoking and tobacco use cessation counseling, greater than 10 minutes
G0436 – Tobacco cessation counseling

Applicable Diagnoses (not an all-inclusive list):

Z71.6 – Counseling and medical advice (tobacco abuse counseling)
Z72.0 - Problems Related to Lifestyle and tobacco use not otherwise specified
Z13.89 - Encounter for screening for other disorder. Use for tobacco use screening.

The Z codes are used if there is NOT dependence on tobacco. The Z codes cannot be combined with an F17 code.

F17 codes include (not an all-inclusive list):

F17.200 - Product unspecified, uncomplicated
F17.201 - Product unspecified, in remission
F17.203 - Product unspecified, with withdrawal
F17.220 - Chewing tobacco, uncomplicated.
F17.229 - Chewing tobacco, with unspecified nicotine-induced disorders.

Visual Acuity Screening (CPT code 99173)
CPT code 99173 (Screening test of visual acuity, quantitative bilateral). This code is for a screening exam and should not be billed for an ophthalmologic service or an

evaluation/management service of the eye. It is very typically used for pediatric vision screenings. Per the CPT instructions for the code, providers usually perform this screening using a Snellen chart, the eye chart that features letters in rows of descending size. For pediatric screenings VCHCP covers the service through 21 years of age. CPT code 99173 may be reported separately in addition to annual well visit services reported with CPT codes 99381-99384 (Initial comprehensive preventive medicine evaluation and management of an individual)/99391-99395 (Periodic comprehensive preventive medicine re-evaluation and management of an individual).

ICD-10-CM codes accepted for the procedure code 99173 are Z01.00, Z00.121, or Z00.129. However, if the screening is part of a routine examination, such as a well child exam, then a screening code may not be necessary. In this case, only the Z00.129 code would be needed.

CPT Code 99174

This code is billed for bilateral instrument-based ocular screening that includes photo screening, interpretation, and a report with remote analysis. This procedure can help identify sight-threatening conditions in children, such as refractive errors, strabismus, retinal abnormalities, and media opacities. This screening is done for children between the ages of 3 and 5 (per USPSTF guidelines). It may be reported separately in addition to annual well visit services reported with CPT codes 99381-99384 (Initial comprehensive preventive medicine evaluation and management of an individual)/99391-99395 (Periodic comprehensive preventive medicine re-evaluation and management of an individual).

ICD-10-CM codes accepted for the procedure code 99173 are Z01.00, Z00.121, or Z00.129. However, if the screening is part of a routine examination, such as a well child exam, then a screening code may not be necessary. In this case, only the Z00.129 code would be needed.

Hearing Screening

Hearing screening is covered for pediatric patients through 21 years of age; it may be reported separately in addition to annual well visit services reported with CPT codes 99381-99384 (Initial comprehensive preventive medicine evaluation and management of an individual)/99391-99395 (Periodic comprehensive preventive medicine reevaluation and management of an individual). Accepted CPT and ICD-10-CM codes for reporting pediatric examination include:

CPT Codes	ICD-10-CM Codes
92551 Screening test, pure tone, air only **92552** Pure tone audiometry (threshold), air only **92567** Tympanometry (impedance testing)	**Z00.121** Routine child health exam with abnormal findings **Z00.129** Routine child health exam without abnormal findings **Z01.10** Encounter for examination of ears and hearing without abnormal findings. **Z01.118** Encounter for examination of ears and hearing with other abnormal findings.

Hearing screening is not covered for adult patients over age 21 for preventive examination. For diagnostic testing of adults with suspected hearing loss or other audiological-related disorders use a non-screening CPT and diagnosis code for reporting.

Billing Development/Autism Screening and Behavioral/Social/Emotional Screening

The Plan accepts the following CPT codes and ICD-10-CM codes:

CPT Codes	ICD-10-CM Codes
96110 Development screening, per instrument, scoring and documentation.	**Z13.41** Encounter for autism screening **Z13.42** Encounter for screening for global development delays (milestones)
96127 Brief emotional/behavioral assessment (eg, depression inventory) with scoring and documentation.	**Z13.31** Encounter for screening for depression **Z13.39** Encounter for screening examination for other mental health and behavioral disorders
G0444 Annual depression screening, 5 to 15 minutes.	**Z13.31** Encounter for screening for depression
96160 Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument.	**Z13.31** Encounter for screening for depression
96161 Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.	**Z00.129** Encounter for routine child health examination without abnormal findings (this diagnosis is billable when screening mothers (caregiver) for postpartum depression post-delivery).

Maternal Mental Health

Depression Screening: Screening should occur at least once during pregnancy, ideally late in the first trimester or early in the second trimester. In the Postpartum Period: At least once, at the six-week obstetric postpartum visit and ideally at least one additional time through the first year after birth. Additional postpartum screenings will be covered if determined to be medically necessary and clinically appropriate in the judgement of the treating provider. Cost sharing and authorization are not applicable for these antepartum or postpartum screenings.

Diagnosis code: Z13.32 Encounter for screening for maternal depression
CPT code for depression in pregnancy: 96127 (Brief emotional/behavioral assessment (e.g., depression inventory)

CPT code for depression postpartum: 96161 (Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory). Billing this code postpartum is appropriate, the mother is now considered a "caregiver."

Billing Preventive Medicine Visits with an Evaluation and Management Service

If a significant, separately identifiable evaluation and management (E/M) service is performed during a Well patient examination by the same physician modifier 25 should be appended to that code. For example, A 38-year-old patient female presents for a well exam and right sided abdominal pain. The Well exam is billed under CPT code 99395 with CPT code 99214 billed on the same claim with modifier 25 as a separate service for the abdominal pain. Cost sharing may be applied to the E/M service.

For pediatric immunizations (through 18 years of age), use administration code 90460 for each vaccine administered. For vaccines with multiple components (combination vaccines), report 90460 in conjunction with 90461 for each additional component within a vaccine.

Vaccines administered to adults are reported with codes 90471 for one vaccine and 90472 for each additional vaccine.

Do not report CPT code 96372 (subcutaneous or intramuscular therapeutic, prophylactic, or diagnostic injection) for vaccine administration, the code will be denied.
For administration of COVID-19 (SARSCOV2) vaccinations report HCPCS code 0001A through 0144A or the most applicable code at the time of service. The administration service will be reimbursed. The cost of the vaccination products is currently covered by the Federal Government and will be denied if providers request reimbursement. Update: Effective 11/01/2023 all previous codes reportable for COVID-19 (SARSCOV2) vaccine products and vaccine administration will be deleted. The CPT codes have been consolidated to include 90480 for all vaccine administration services and 91318-91322 for vaccine products.

The Plan covers the administration of monoclonal antibody treatments without cost-sharing to members when billed to treat SARS-CoV-2 (COVID-19) during the public health emergency.

During the SARS-CoV-2 (COVID-19) public health emergency prior authorization or cost sharing will not be applied for COVID-19 diagnostic and screening testing and health care services related to the testing for COVID-19. Claims billed for these services must contain appropriate ICD-CM-10 diagnostic codes which describe *asymptomatic* or *symptomatic* actual or suspected exposure to COVID-19. For *symptomatic* screening testing and health care services related to the testing for COVID-19 bill symptom diagnoses in conjunction with the symptomatic actual or suspected exposure to COVID-19 diagnosis.

Add-on Codes

Add-on codes are a specific type of supplemental procedure code describing additional intra-service work associated with the primary procedure performed, e.g., additional digit(s), lesion(s), neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s), vaccine(s), minute(s), hour(s), etc. Add-on procedures or services are performed by the same physician performing the primary service at the same surgical session or patient encounter.

Add-on codes can be found in both CPT codes (Level I HCPCS codes) and HCPCS codes (Level II HCPCS codes). The primary procedure code and the add-on code form a pair of connected services on the claim. The primary procedure code or service may also sometimes be referred to as the "parent code" for the add-on procedure code. Add-on codes may not be billed without an accompanying primary procedure code; when this occurs, the add-on code is considered an "orphan code" which has been incorrectly billed. Add-on codes can be readily identified by specific phrases in the code description such as "each additional," or "(List separately in addition to primary procedure)."

Coding Guidelines

- Add-on codes are always performed in addition to the primary service or procedure and may not be reported as a stand-alone code.
- The add-on code concept applies only to add-on procedures or services performed by the same physician; therefore, add-on codes may not be reported by a different physician or provider.
- Add-on codes are exempt from the multiple procedure concept, and therefore, modifier -51 cannot be appended to these codes.
- Add-on codes can be found in multiple sections of CPT, including the surgery and evaluation and management section. For example, reporting CPT code 99292 with 99291.
- An add-on code is eligible for payment only if one of its primary codes is also eligible for payment.

Direct Specialty Referral for Contracted Providers

The purpose of the Direct Specialty Referral process for VCHCP members is to facilitate member referrals from contracted providers to contracted specialists for consultation, follow up visits and subsequent in office and non-in office procedures and diagnostic testing. A specific referral process and referral form has been developed and provided to primary care providers for use in making direct referrals. The following are Procedures and Services included with Direct Referrals and do not require prior authorization from the specialists as applicable for Contracted Providers' offices and Selected Facilities only. Tertiary care requires prior authorization for all specialist services.

Allergy and Immunology – The following services do not require prior authorization when performed by a contracted provider (Except Tertiary):

- All allergy services, including testing (e.g., 95004, 95017) and immunotherapy (e.g., 95115, 95117)
- Evaluation & Management (CPT codes 99202-99205, 99211-99215)

- Administration of some vaccines related to the immune and respiratory system, such as the influenza vaccine, Prevnar, Prevnar 13 and Pneumovax
- Cost sharing is applicable except for immunotherapy services (injections/serums).

Dermatology – The following services do not require prior authorization when performed by a contracted provider (Except Tertiary):

- Office procedures: destruction of lesions by any method and repair, biopsy and excision of lesions and repair, Moh's procedures except when plastic surgery is required for closure. Examples of services include (not an all-inclusive list):
- Paring or Cutting lesions: 11055-11057
- Biopsies: 11102-11107
- Shaving of epidermal or dermal lesions: 11400-11471
- Excision of malignant lesions: 11600-11646
- Pilonidal cyst: 11770-11772
- Introduction (intralesional): 11900-11901
- Repair: 12001-12057 (simple repair), 12031-12057 (intermediate repair), 13100-13160 (complex repair).
- Destruction of lesions: 17000-17286
- Other procedures: 17340-17380
- Evaluation & Management: CPT codes 99202-99205, 99211-99215.

Services which may require authorization include (not an all-inclusive list):

- 14000-14350 (adjacent tissue transfer, or rearrangement
- 15002-15777 (skin replacement surgery when plastic surgery is required for closure).
- 17311-17315 (Mohs micrographic surgery when plastic surgery is required for closure).
- Unlisted dermatology services (e.g., CPT code 17999) require medical necessity review and a description of the service on the claim form. Medical records may be requested if the criteria have not been met.

Endocrinology – The following services do not require prior authorization when performed by a contracted provider (Except Tertiary):

- Thyroid FNA biopsy: 10021
- Evaluation & Management: 99202-99205, 99211-99215

Select providers may perform diabetes medical services such as medical nutrition therapy (MNT), education counseling, and outpatient self-management training – Refer to the Direct Specialty Referral grid/Endocrinology online at www.vchealthcareplan.org for additional information.

ENT (otorhinolaryngology) – The following services do not require prior authorization when performed by a contracted provider (Except Tertiary):

- Evaluation & Management
- Oronasal endoscopy (CPT code 31231)
- Laryngoscopy office procedures (CPT codes 31505, 31510, 31511 and 31575)

- Removal of cerumen (CPT code 69209)
- Nasal endoscopy (CPT codes 31231, 31233, 31235 and 31237)
- Use of binocular microscope (CPT code 92504)
- Nasopharyngoscopy (CPT code 92511)
- Removal of foreign body from external ear canal (EAC) (CPT code 69200)
- Excision of lesion vestibule of mouth without repair (CPT code 40810)
- Biopsy of anterior tongue (CPT code 41100)
- Biopsy of lip (CPT code 40490)
- Excision of tongue lesion without closure (CPT code 41112)
- Biopsy floor of mouth (CPT code 40808)
- Biopsy of oropharynx (CPT code 42800)
- Incision & drainage of peritonsillar abscess (CPT code 46040)
- Control of nasal hemorrhage, anterior (CPT code 30901)
- Simple fine needle aspiration of thyroid without image guidance (CPT code 10021)
- Thyroid core biopsy (CPT code 60100)
- Adult tympanostomy tube placement under local anesthesia (CPT code 69433)
- Audiometry testing (CPT code 92550, 92552, 92553 and 92555)
- Tympanometry (CPT code 92567)

Other services require prior authorization. Unlisted service CPT codes require a description of the service on the claim form and medical necessity review. Medical records may be requested.

Gastroenterology – The following services do not require prior authorization when performed by a contracted provider (Except Tertiary):

- Evaluation & Management
- Screening and diagnostic colonoscopy
- Other endoscopically performed GI procedures (refer to VCHCP's Prior Authorization Reduction List for further guidance and applicable CPT codes)

Unlisted services require prior authorization. Screening (preventive) colonoscopy does not have a cost share. Refer to the section in this manual addressing the billing of colonoscopy services for further information.

General Surgery – The following services do not require prior authorization when performed by a contracted provider (Except Tertiary):

- Evaluation & Management
- Needle Biopsy
- Excision of lesions (non-cosmetic)
- Psychiatric Diagnostic Evaluation (90791) associated with gastric bypass.

Hematology/Oncology – The following services do not require prior authorization when performed by a contracted provider (Except Tertiary):

- Evaluation & Management

- Complete blood count (CBC) – CPT code 85025
- Ferritin – CPT code 82728

Other services such as injections and chemotherapy require prior authorization. Cost sharing is applicable.

Neurology and Neurosurgery – The following services do not require prior authorization when performed by a contracted provider at a contracted facility (Except Tertiary):

- Evaluation & Management
- Routine EEG (electroencephalography) – CPT codes 95812-95822
- Electromyography (EMG) and nerve conduction studies (NCV) - CPT codes 95860-95887

Refer to the Direct Specialty Referral grid/Neurology and Neurosurgery online at www.vchealthcareplan.org for additional information.

Obstetrics/Gynecology (OB/GYN) – Services covered for direct access to contracted providers include obstetrical and gynecological services such as pregnancy, well-woman gynecological exams, primary and preventive gynecological care and acute gynecological conditions. Cervical cancer screening shall include the conventional Pap test, human papillomavirus (HPV) screening test approved by the FDA and the option of any FDA-approved cervical cancer screening test and will be covered based on the frequency recommended in the Plan's most recently approved Preventive Health Guidelines.

Services listed in the Direct Referral Process for OB/GYN include:

- Evaluation & Management (E&M) Codes
- Office Procedures: Colposcopy and biopsy, endometrial biopsy, insertion and removal of IUDs for contraception, insertion of Mirena for control of menorrhagia or endometrial hyperplasia, vulvar biopsy, insertion of Nexplanon.

CPT Coding for Maternity Visits

Antepartum Care Only	1-3 visits	Use E&M Codes
Antepartum Care Only	4-6 visits	59425
Antepartum Care Only	7 or more visits	59426
Postpartum Care		59430

CPT codes for Maternity Services include: 59400-59622

When billing for preventive cancer screening including only a pelvic and breast examination the following code combination is acceptable:

G0101: Cervical or vaginal cancer screening; pelvic and clinical breast exam (CA screen; pelvic/breast exam).
Q0091: Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory (obtaining screening Pap smear).

Orthopedics – The following services do not require prior authorization when performed by a contracted provider at a contracted facility (Except Tertiary):

- Evaluation & Management
- Arthrocentesis (e.g., CPT codes 20600, 20604, 20605, 20606, 20610 and 20611)
- Fracture Care (e.g., CPT codes 24500, 28510)
- Casting and Immobilization (e.g., CPT codes 29065, 29075, 29085 and 29086)
- Hyaluronate Derivative Injection (HCPCS codes J7321, J7325)
- Dispensing Selected Prefabricated Orthotics (Refer to the VCHCP Prior Authorization Reduction List of Orthotics Contracted Orthopedists May Dispense)

Surgery and Other Services that require prior authorization include CPT Codes such as (not an all-inclusive list):

- 23120 – Claviculectomy; partial
- 23406 – Tenotomy, shoulder area; multiple tendons
- 24105 – Excision, olecranon bursa
- 24332 – Tenolysis, triceps
- 27420 – Reconstruction of dislocating patella

Services performed in-office by an Orthopedist have a cost share.

Physical Therapy: Electrical Stimulation – HCPCS code G0283

For physical therapy services CPT code 97014 – Electrical stimulation (unattended) (to one or more areas) is not recognized by VCHCP. VCHCP requires the use of code G0283 for electrical stimulation (unattended) instead.

Refer to the Direct Specialty Referral Policy for Guidelines on the Number of Visits Allowed Without the Requirement of Prior Authorization

Plastic Surgery – The following services do not require prior authorization when performed by a contracted provider (Except Tertiary):

- Evaluation & Management
- Biopsies (Example CPT codes include 11102, +11103, 11104, +11105, 11106, +11107)
- Steroid injections for trigger finger, scar management and finger joint pathology (CPT code 20550).

Other procedures that are covered but require prior authorization include reconstructive surgery performed to restore function and normal appearance and correct deformities

created by birth defects, trauma, or medical conditions including cancer. Examples include cleft lip and palate repair, breast reconstruction following a lumpectomy or mastectomy for breast cancer, and reconstructive surgery after burn injuries.

Plastic surgery related to Gender Affirming procedures is covered and requires prior authorization.

Cosmetic surgery performed by a plastic surgeon to enhance overall cosmetic appearance by reshaping and adjusting normal anatomy to make it more visually appealing is not covered. Unlike reconstructive surgery, cosmetic surgery is not medically necessary. Procedures like breast augmentation, breast lift, liposuction, abdominoplasty, and facelift are considered non-covered when performed for cosmetic-related enhancement. Diagnosis Z41.1 (Encounter for cosmetic surgery) is not covered.

All claims billed with code 17999 (unlisted procedure, skin, mucous membrane, and subcutaneous tissue) or other unlisted procedures require medical necessity review.

Podiatry – The following services do not require prior authorization when performed by a contracted provider (Except Tertiary):

- Evaluation & Management
- Trimming of nails for diabetic patient only – CPT code 11719
- Debridement of nails (CPT code 11720-11721)
- Avulsion of nail plate (CPT codes 11730-11732)
- Excision of nail and nail matrix, partial or complete for permanent removal (e.g., ingrown or deformed nail (CPT code 11750)
- Paring/cutting hyperkeratotic lesions (CPT codes 11055-11057)
- Injection(s), single tendon sheath (CPT code 20550)
- Arthrocentesis, aspiration and/or injection of a small joint or bursa (CPT code 20600)
- Aspiration & injection of a ganglion cyst any location (CPT code 20612)
- Injection(s), anesthetic agent(s), and/or steroid; sciatic nerve, incl. imaging guidance (CPT code 64445)

Other podiatry services and orthotics require prior authorization.

Pulmonology – The following services do not require prior authorization when performed by a contracted provider (Except Tertiary):

- Evaluation & Management
- Spirometry – CPT codes 94060, 94070 and 94070
- Vital capacity total – CPT code 94150, 94200
- Respiratory flow volume – CPT code 94375
- Pulmonary stress test – CPT codes 94620, 94621
- Pressurized/non pressurized inhalation treatment – CPT code 94640
- Demonstration/evaluation of patient utilization (nebulizer, IPPB) – CPT code 94664
- Oxygen uptake expiration of gas analysis (CPT codes 94680, 94681 and 94690)
- Plethysmography lung volumes (CPT code 94726)
- Diffusing capacity (94729)

- Carbon dioxide expiration gas determination (CPT code 94770)

Other services may require prior authorization. Unlisted service CPT codes require a description on the claim form and medical necessity review. Medical records may be required. Cost sharing is applicable to pulmonology services performed in-office.

Radiology – The following services do not require prior authorization when performed by a contracted provider (Except Tertiary):

- Most radiological imaging studies.
- Plain x-ray, ultrasound, screening mammogram
- All radiological imaging studies performed at Ventura County Medical Center **except** DEXA scan (non-preventive), MRI/MRA/MRV, PET scan, tagged white/red cell scan, VQ scan and nuclear medicine imaging.

Radiology Subsections of the CPT coding system include:

Diagnostic radiology (diagnostic imaging)	70010-76499
Diagnostic ultrasound	76506-76999
Radiologic guidance	77001-77022
Breast, mammography	77046-77067
Bone/joint studies (requires prior authorization)	77071-77086
Radiation oncology (requires prior authorization)	77261-77799
Nuclear medicine (requires prior authorizations)	78012-79999

Unlisted service CPT codes require a description on the claim form and medical necessity review. Medical records may be requested.

Radiology Service Modifiers include:

-26	Professional component
-76	Repeat procedure by same physician
-77	Repeat procedure by different physician
-LT	Left side of body
-RT	Right side of body

Services requiring prior authorization include non-preventive DEXA scans, MRI/MRA/MRV, PET scan, tagged white/red cell scan, VQ scan and nuclear medicine imaging. Authorization may also be required for contrast agents and radiopharmaceuticals billed with these services.

Contrast HCPCS codes (A4641, A4642, Q5101-Q9969)
Radiopharmaceutical HCCPS codes: (A9500-A9699)

Except for preventive services cost sharing is applicable.

Rheumatology – The following services do not require prior authorization when performed by a contracted provider (Except Tertiary):

- Evaluation & Management
- Joint aspiration – CPT codes 20600, 20605 and 20610 and 20615

Other services performed in-office by a rheumatologist require prior authorization. Cost sharing is applicable.

Thoracic and Vascular Surgery – The following services do not require prior authorization when performed by a contracted provider at a contracted facility (Except Tertiary). Cost sharing is applicable for in-office services performed by the specialist.

- Evaluation and Management

Surgical services require prior authorization. Unlisted service CPT codes require a description on the claim form and medical necessity review. Medical records may be requested. An example of surgery services performed by this specialty may include (not an all-inclusive list):

21750 – Closed median sternotomy

31600 – Tracheostomy planned separate procedure

32440 – Removal of lung pneumonectomy

32650 – Thoracoscopy with pleurodesis

33050 – Resection pericardial cyst/tumor

Obstetric (OB) Triage

Common scenarios where the member presents for obstetric triage can include such conditions as preterm contractions and/or labor, vaginal discharge, pre-term, pre-eclampsia evaluation and term vaginal bleeding evaluation. OB triage may also be a setting where women with nonemergent obstetric and medical conditions present when their usual source of medical care is inaccessible or unavailable.

OB triage can be billed if the patient is not an "inpatient." In hospitals pregnant women are sent to an OB triage nurse in the labor and delivery department bypassing physician assessment in the emergency department. The nurse then calls a doctor on call for care and the patient is either admitted for observation or sent home after a few hours.

Billing OB Triage

OB triage charges for services such as nursing and fetal monitoring are consolidated under revenue code 0720 (no HCPCS is required however the plan will accept revenue code 0720 billed with office visit codes). Do not bill revenue code 0720 more than once on the claim for the same service date. Ancillary services for intravenous (IV) infusion, ultrasound, laboratory, drugs and supplies should be billed separately under their respective revenue code(s). If the patient is admitted to observation, then revenue code 0762 can be billed separately and requires a HCPCS code. The Plan accepts revenue code 0720 and 0762 billed together when appropriate for the case; the patient's medical record must contain an order for observation.

OB triage is billed under UB-04 Revenue Code 0720 (Labor Room/Delivery – General):

Claim Example

Line	Code	Description	HCPCS/CPT

1	0300	Lab	36415
2	0301	Chemistry Test	80053
3	0301	Chemistry Test	82570
4	0305	Hematology Test	85027
5	0307	Urology Test	81000
6	0309	Other Lab Test	86850
7	0309	Other Lab Test	86900
8	0720	Delivery Room/Labor	(HCPCS not required)

OB triage charges are generally consolidated under revenue code 0720, except for ancillary services eligible for separate billing such as ultrasound, laboratory, drugs and supplies. In the above example the diagnoses are 047.9 (False labor unspecified) and 024.419 (Gestational diabetes mellitus in pregnancy unspecified control).

Incorrect Billing

Example - Monitoring the patient in a labor & delivery room without admittance to observation.

If a provider bills revenue code 0720 (Labor/Delivery Room general) with revenue code 0762 (observation hours) without the patient's medical record containing an MD order for observation, then billing revenue code 0762 is incorrect and not payable (such as in the example below):

Primary diagnosis: False labor before 37 complete weeks gestation third trimester

Line	Code	Description	HCPCS/CPT
0270		Medical/surgical supplies	
0402	76815	Ultrasound	76815
0720	59025	Delivery Room/Labor	59025
0762		Observation hours	

Note: When an MD order for observation is contained within the patient's medical record a HCPCS code is required for revenue code 0762.

Eligibility and Authorization

Providers are responsible for verifying eligibility and benefits before providing service to VCHCP members. Except for in an emergency, failure to obtain prior authorization for services requiring authorization will result in a denial for reimbursement. A list of services requiring prior authorization can be found at www.vchealthcareplan.org, under 'Provider Connection/Health Services Approval Process/Services Requiring Prior Authorization/Prior Authorization Guide'.

Refunding Overpayments

If you have received an overpayment, please submit the following information:

- A check issued to Ventura County Health Care Plan in the amount of the overpayment.
- The name and ID number of the member for whom we have overpaid
- The dates of service
- Supporting documentation, including but not limited to:
  - A letter explaining the reason for the refund
  - A copy of your Remittance Advice (RA)
  - Any other documentation that would assist in accurate crediting of the refund

Please mail the information to the address listed below.

If we identify an overpayment and request a refund, please mail the check along with the copay of the overpayment request letter we sent you.

Mail this information to:
Ventura County Health Care Plan
2220 E. Gonzales Rd., Suite 210B
Oxnard, CA 93036

If VCHCP determines that an overpayment has occurred, VCHCP will notify the provider of service in writing within 365 days of the date of payment on the overpaid claim through a separate notice that includes the following information:

-Member name
-Claim ID number
-Date of service
-A clear explanation of why VCHCP believes the claim was overpaid
-The amount of overpayment, including interest and penalties

The provider of service has 30 working days to submit a written dispute to VCHCP if the provider does not believe an overpayment has occurred. At this point, VCHCP will treat the claims overpayment issue as a provider dispute.

If the provider does not dispute the overpayment, the provider of service must reimburse VCHCP within 30 working days from the receipt of VCHCP's notice.

VCHCP may recoup uncontested overpayments by offsetting overpayments from payments for a provider's current claims if:

-The provider's Provider Services Agreement (PSA) with VCHCP authorizes it to offset overpayments from payments for current claims for services.

-A written notification is sent to the provider of service if an overpayment is recouped through offsets to claim payments via an agreement entered into by VCHCP and the

provider. The notification will identify the specific overpayment and the claim ID number.

Claim Attachments

Detail of Charges

Occasionally, VCHCP may ask you to provide an itemization of charges (e.g., exception service 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 which includes the determination date. A copy of the other carrier's identification card is helpful, but not necessary for processing (see Coordination of Benefits information further in this manual).

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

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 E for a complete discussion of the rules relating to COB.

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:

- Non-contracted Provider –
    - New claims: within 180 calendar days from the last date of service.
    - Resubmission claims: within 180 calendar days from the Plan's last determination date specified on the remittance advice.
- Contracted Provider –
    - New claims: within 180 calendar days or the time frame specified in your contract; whichever is greater.
    - Resubmission claims: within 180 calendar days or the time frame specified in your contract from the Plan's last determination date specified on the remittance advice.
- Claims requiring coordination of benefits with another carrier: within 180 days (or the time frame specified in your contract) of the primary carrier's payment determination date.
- Initial Appeals: within 365 calendar days of the last VCHCP payment or decision, or the time frame specified in 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 involving a billing dispute or other contractual dispute that are not submitted within these time frames.

Claims Processing Under Assembly Bill 72 (AB72): Out-of-Network Coverage

On September 23, 2016, AB 72 was signed by the California Governor to be effective July 1, 2017. AB 72 (Section 1371.9 of the Health and Safety Code) is applicable when a patient receives covered, non-emergency services at a contracting health facility (hospital, ambulatory surgery center, laboratory, radiology or imaging center) from a non-contracting individual health professional. An individual health professional is defined as a physician, surgeon or other professional (excluding dentists) who is licensed by the state of California to furnish health care services.

Under AB72 non-contracting individual health care professionals are entitled to be reimbursed by the patient's (enrollee's) health insurer at the greater of 125% of the

Medicare Fee Schedule Rate or the payer's average contracted rate (ACR) for similar services in the same geographic area. If applicable, when patient (enrollee) cost-sharing (includes copayment, coinsurance or deductible) is involved a non-contracting individual health professional may only bill for or collect the in-network cost sharing amount as determined by the plan.

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 (PDR) mechanism is accessible to both contracting and non-contracting providers.

Non-contracting individual health care professionals paid under AB 72 are required to utilize this mechanism to submit a dispute for a minimum of 45 working days or until receipt of the plan's written determination, whichever is shorter, prior to utilizing the independent dispute resolution process (IDRP) through the DMHC's contracted IDRP organization.

Independent Dispute Resolution Process

As of September 1, 2017, in response to Assembly Bill (AB) 72, an Independent Dispute Resolution Process (see Appendix G for filing steps) was established which allows a non-contracted provider who provided service at a contracted facility (as described above) or a payor to dispute whether payment of the specified rate was appropriate**.** Providers must use the PDR process prior to submission to the Department of Managed Health Care (DMHC).

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 and 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. incorrect units of service, incorrect 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 complete (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 following 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.

Unjust payment pattern

The following are examples/scenarios of unjust payment patterns:

- Imposing a claim filing deadline for the receipt of a claim that is less than 90 days for contracting providers or 180 days for non-contracting providers after the date of service and imposing a date less than 90 days from the primary payers determination, when paying as a secondary/tertiary payer.
- Failing to forward at least 95% of misdirected, non-emergent 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 and refers contracting providers initially upon contracting to the Provider Operations Manual, or upon change of the Provider Dispute Resolution Process, of the procedures for submitting a Provider Appeal, including:

- Information on the Provider Dispute Resolution Mechanism for Provider Appeals
- Mailing address
- Telephone number
- Directions for filing an Appeal
- The timeframe in which VCHCP will review and provide a resolution of the Appeal

Remittance Advice

The Remittance Advice (RA) informs providers of the availability of VCHCP's Provider Dispute Resolution Process and provides instructions for filing a Provider Appeal. A RA is sent each time VCHCP processes a provider submitted claim. RAs 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/Relations Department is responsible for the Provider Dispute Resolution Process.

VCHCP's Senior Management is responsible for:

1. The maintenance of the Provider Dispute Resolution Process;
2. Review of the Provider Dispute Resolution operations;

3. Noting any emerging patterns to improve administrative capacity, VCHCP Provider Relations, claim payment procedures and patient care;
4. 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

California Code of Regulations (CCR), title 28, Section 1300.71.38 requires health plans to offer an appeal process. VCHCP's Provider Dispute Resolution Process consists of two levels: Initial and Final.

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 (NPI) and/or the provider's EIN
- Contact information - mailing address and phone number
- The patient's name
- 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 claim 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 Dispute 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 overpaid. 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 Dispute 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 and 2 business days for those received electronically.

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.

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 and Substance Use Disorder	10 business days	48 hours	96 hours
Waiting time in a provider office (to speak with a triage nurse)		30 minutes	
Ensure wait time for enrollees to speak with qualified representative during business hours		Not to exceed 10 minutes	

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.

After-Hours Services

The VCHCP expects all contracted providers to maintain appropriate after-hours services or provide members with clear instructions on how to obtain appropriate after-hours services via a telephone answering service or recorded message. The Plan audits all new providers and performs an annual "after-hours survey" of its contracted providers and audits the following:

- Does the office have a telephone answering machine and/or an answering service/office staff that will inform the caller on how to call 911 in the event of an emergency?
- Are there instructions for how the caller may obtain urgent or emergency care and/or how to contact the on-call physician?
- Does the message provide the regular business hours?
- Does the message give information regarding the length of wait for a return call from the provider?

- If the provider has self-identified as being bilingual; is the message bilingual (for the purposes of this survey the Plan was only concerned with those providers who self-identified as being a Spanish speaker and only checked to see if the message was recorded in English and Spanish)?

Providers found to be out of compliance with the above will receive written notice from the Plan. The VCHCP will then re-survey those providers between 30 and 60 days from the date of the notice.

Appendix B - Member Grievances, Complaints and Appeal Process

Purpose and Scope

Ventura County Health Care Plan (VCHCP) has a Grievance and Appeals Program that meets the requirements of the Knox-Keene Health Care Service Plan Act of 1975, and the regulations promulgated thereunder. VCHCP will ensure that a mechanism exists to process Member Grievances and Appeals in a consistent manner.

VCHCP recognizes that, under certain circumstances, our performance or that of our contracted providers, may not agree with or match our members' expectations. Therefore, the Plan has established a system for the Plan members to file a grievance/complaint or appeal. We endeavor to assure our members of their rights to voice complaints and appeals of any adverse determination of complaints, and to expedite resolutions. This policy refers to complaints and grievances and their appeals. For coverage appeals regarding delay, denial, or modification of services based on a determination in whole or in part that the service is not medically necessary, please refer to the Appeal Process for Medical Necessity in Appendix C.

Guidelines

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. (The Plan seeks the approval of its process by the Department of Managed Health Care [DMHC]).

The Director of Member and Provider Services, Christina Woods, has been designated as having primary responsibility for the Plan's grievance and appeal system to ensure appropriate oversight and administration of all aspects, including monitoring, reviewing, and reporting to identify emerging patterns of grievances and improve plan policies and procedures.

VCHCP documents research, interim and final responses to the member, as well as telephonic and written responses to members' concerns through the grievance/complaint and appeals process. This ensures that all concerns by Plan members are resolved in a fair and timely manner. This process has been developed to address various levels of concerns by members including general inquiries, grievances, and appeals procedures. It also facilitates the categorizing of member concerns via an online system.

It often requires a series of events to truly identify one overall situation or trend. Accordingly, the Grievance/Complaint and Appeals tracking system provides information that empowers the Plan with the opportunity to continually monitor and improve the level of care and services it provides to members. Trends are analyzed and reported quarterly to the Member/Provider Experience Committee (MPEC), Quality Assurance (QA) and Standing Committees.

Members have the right to voice a concern about the benefits, services, access, continuity of care and quality of care provided by the Plan, Plan Providers, and Plan Facilities. VCHCP, its Plan Providers and Facilities will not discriminate against members who have chosen to file a grievance. 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 member or subscriber, immediate steps will be taken to rectify the situation and prevent such conduct in the future.

1. The Plan shall conduct a thorough investigation of the incident.
2. The Plan shall determine whether or not adverse action was taken against such member or subscriber.
3. The Plan shall take disciplinary action against the offending Plan employee(s) who took adverse action against such member or subscriber.
4. If no adverse action was taken against such member or subscriber, the Plan shall close the investigation and save all logs, interview notes, the conclusion, and all other evidence gathered as part of the investigation in a secure electronic storage to protect private information which may have been accumulated during the investigation.

Enrollees 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 Medical Director of the Plan.

Definitions

Grievance/Complaint: A grievance/complaint means a written or oral expression of dissatisfaction regarding the Plan and/or provider by either a Plan member or their representative, including the member's provider(s). 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, but are not limited to, concerns about quality of care, access to care, delay of care, and 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 other representative may file appeals. Appeals may be requested for a denial of claims, denial of benefit or other denial of coverage. Appeals may also be applicable for some complaints when a member receives an adverse decision.

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. This also applies to grievances specific to cancellations, rescissions, and non-renewals of enrolment.

Resolved: Grievance/complaint or appeal has reached a final conclusion (no pending member appeals).

Procedure for Grievances/Complaints

Information regarding the grievance/complaint procedures for receiving and resolving grievances/complaints is available in the Plan's Evidence of Coverage (EOC), which is made available to all eligible members via the Plan's website and/or in print upon request

by calling Member/Provider Services at (805) 981-5050 or (800) 600-8247. Members may register grievances/complaints with VCHCP by form, letter, fax, online, or by calling or writing:

Ventura County Health Care Plan
2220 E. Gonzales Rd. Ste. 210-B
Oxnard, CA 93036
(805) 981-5050 or **(800) 600-VCHP**

For free Language Assistance services or cultural assistance, including interpreter services, call VCHCP at (805) 981-5050. For TDD/TTY for the hearing impaired, call (800) 735-2929 to communicate in English or (800) 855-3000 to communicate in Spanish. In addition, the Plan's website provides an on-line form that an enrollee may use to file a grievance on-line via a secure portal. The link to this on-line Grievance Form is found on the right-hand side of the Plan's web portal page, (http://www.vchealthcareplan.org/members/memberIndex.aspx). Forms may also be obtained by calling Member Services at (805) 981-5050 or (800) 600-8247.

A member may appoint an Authorized Representative, such as a legal guardian, conservator or relative, who can also submit a grievance to the Plan.

This appointment must be in writing. Members can obtain an Authorized Representative form to submit by calling Member Services or visiting VCHCP in person.

The following persons may be submitted and considered as an authorized representative:

- A friend, relative or legal representative;
- A parent of a child under 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of relevant information;
- A court- appointed guardian, except the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of relevant information;
- A court-appointed conservator;
- An agent under a currently effective health care proxy, to the extent provided under state law;

A member's provider can also submit grievances to the Plan and/or the DMHC.

VCHCP encourages the informal resolution of problems and complaints, especially if they resulted from misinformation or misunderstanding. However, if a complaint cannot be resolved in this manner, a formal Member Grievance Procedure is available.

The Member Grievance Procedure is designed to provide a meaningful, dignified, and confidential process for the hearing and resolving of problems and complaints. VCHCP makes available complaint forms at its offices and provides complaint forms to each Participating Provider. A member may initiate a grievance in any form or manner (form, letter, fax, telephone call, or online) to the Member Services Department, and when VCHCP is unable to distinguish between a complaint and an inquiry, the communication shall be considered a complaint that initiates the Member Grievance Procedure.

Members are advised, via statement on the grievance/appeals form, that after participating in the process for at least 30 days, they may submit the grievance to the DMHC for review. Further, the member is advised via statement on the grievance/appeals form, 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.

The Plan provides written acknowledgment of a member's grievance and ongoing investigation within five (5) days of receipt unless the grievance is received by telephone and can be resolved within the same day. For those grievances/complaints that can be resolved within 5 days or less of receipt, the written statement to the complainant of the resolution will stand as the receipt of notification and resolution. The Plan provides for the receipt, handling and resolution of grievances, including a written response to a grievance, within thirty (30) days. The Plan may extend the timeframe for resolution of appeals by up to 14 calendar days if the member requests the extension or if the Plan shows there is need for additional information and that the delay is in the member's best interest. If additional time (beyond the 30 days) is needed to resolve the complaint, procedures are in place to notify the member (in writing) prior to the 30th day. If, however, the case involves 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, the Plan shall provide an expedited review. The Plan shall provide a written statement on the disposition or pending status of a case requiring an expedited review no later than three (3) days from receipt of the grievance. See expedited review section below.

Quality of care complaints are elevated to the Medical Director, or designee, to review for Potential Quality Issue (PQI). Additionally, the Director of Member and Provider Services may request review by the Medical Director or designee for any other appropriate issue. 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.

Members may file grievances for up to 6 months (180 calendar days) following any event or action that is subject to the members' dissatisfaction.

Records of grievances/complaints are maintained by the Plan for no less than 5 years. 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.

Expedited Review of Grievances

The Plan's grievance/complaint system includes procedures for the expedited review of grievances for time sensitive situations for cases involving an imminent and serious threat to the health of the patient, including but not limited to, severe pain, potential loss of life, limb, or major bodily function.

When the Plan is notified of a case that requires urgent review, the Plan will advise the Plan member of their right to notify the DMHC of the urgent grievance by letter sent via U.S. mail within 3 business days. Further, the Plan shall, no later than 3 days from the receipt of the urgent grievance, notify the Plan member and the DMHC in writing of the

disposition or pending status of the urgent grievance.

Grievances and Appeals Pertaining to Terminally Ill Members

If a grievance/complaint is received pertaining to a member with a terminal illness, the Plan shall provide the member with a statement setting forth the specific medical and scientific reasons for denying the coverage.

The Plan shall provide the member with a description of alternative treatments, services and/or supplies covered by the Plan.

The member shall also, within five (5) days, be provided with copies of the Plan's Grievance procedures and Complaint forms, with an offer to attend a conference with the Plan within 30 calendar days.

Plan Personnel Responsible for Handling Urgent Grievances

Contact Person:

Christina Woods, Director of Member and Provider Services
During Business Hours:
Member Services: (805) 981-5050
Toll-free: (800) 600-VCHP
E-mail: Christina.Woods@ventura.org
Office: (805) 981-5086

Or

Erick Hernandez, Manager – Customer Service
During Business Hours:
Member Services: (805) 981-5050
Toll-Free: (800) 600-VCHP
E-mail: Erick.Hernandez@ventura.org
Office: (805) 981-5121

Alternate Contact Person:

Faustine Dela Cruz, RN, Health Services Director, UR Manager
During Business Hours:
Utilization Management (UM) Services: (805) 981-5060
Toll-free: (800) 600-VCHP
E-mail: Faustine.DelaCruz.@ventura.org
Office Phone: (805) 981-5058

Medical Director:

Howard Taekman, M.D., Medical Director
During Business Hours:
Customer Service: (805) 981-5050
Toll-free: (800) 600-VCHP
E-mail: Howard.Taekman@ventura.org
Office Phone: (805) 981-5024

Appeal Rights

Members are notified of their appeal rights for grievances/complaints at several times during the grievance process.

VCHCP provides members with written responses to complaints. Responses are to include a clear and concise explanation of the reasons for the response.

- For grievances involving the delay, denial, or modification of services based on a determination in whole or in part that the service is **not medically necessary,** VCHCP will, in its written response, describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity (which will be substantiated by our medical necessity criteria). It also includes that the determination may be considered by the Department's independent medical review system. An application will be provided with an envelope addressed to the DMHC in Sacramento.
- For 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, VCHCP, in its written response, will clearly specify the provisions in the Evidence of Coverage that exclude that coverage.

The Department of Managed Health Care (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 on the initial Grievance/Complaint form, in their Evidence of Coverage (EOC), on the VCHCP five-day notification correspondence, disposition correspondence, and in notices relating to denial of services 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). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online."

Members are advised at the time of the complaint 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.

A member's legal guardian, conservator, or relative can also submit appeals to the Plan or the DMHC.

Members are expected to use the Plan's appeal procedures first to attempt to resolve any dissatisfaction. Please see the section below on appeals for details. 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.

Providers, including participating and non-participating physicians may assist the member in submitting a complaint to the department for resolution and may advocate the member's cause before the department. No provider may be sanctioned by VCHCP for giving such assistance to a member.

The DMHC has 30 days from receipt of an IMR request to send the member and VCHCP a written notice of their determination (which the DMHC refers to as the notice of "final disposition of the grievance"). (See IMR Policy, QA Program).

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 they determine that it was a covered service and was medically necessary.

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.

Appeals

Appeals made to the Plan for adverse decisions of grievances and complaints are handled primarily by the Member Services Department. Appeals arising from adverse coverage decisions are generally handled by the UM department and are addressed in the Appeals section, Appendix C. Members are notified of the appeals process in the EOC, which is made available to all eligible members via the Plan's website and/or in print upon request by calling Member/Provider Services at (805) 981-5050 or (800) 600-8247. This information includes the Plan's local and toll-free number, access to telephone relay systems, notification of linguistic services and cultural assistance. Also included is the DMHC's appeals process, the Independent Medical Review System and the DMHC's toll-free number and website address.

A member, a member's legal guardian, conservator, or relative can submit an appeal to the Plan or to the DMHC.

VCHCP will retain records of appeals for a period of at least 5 years. Information that the Plan is required to maintain includes a copy of all medical records, documents, evidence of coverage and other relevant information upon which the Plan relied to reach its decision.

As stated in the Appeal Rights section, members are expected to use the Plan'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.

Appeals may be received by the Plan in writing, by telephone, fax or online through the website.

Appeal determinations will be made within 30 days of the receipt of the appeal. The member will be notified in writing, by that time, of the Plan's decision.

As with a grievance, an adverse decision on a first appeal/second level review can be appealed further. If the first appeal has been unresolved for more than 30 days or was not satisfactorily resolved by the Plan, the member may seek assistance from DMHC, as stated in the appeal notification letter and the EOC.

For urgent appeals, the same process applies as with an expedited review. See section on Expedited Review.

MEDIATION

The member and dependents may request that an unresolved disagreement, dispute or controversy concerning any issues including the provision of medical services, arising between the member and dependents, the member's heirs-at-law, or personal representative, and VCHCP, its employees, Participating Providers, or agents undergo voluntary mediation.

If a member seeks voluntary mediation, he or she must send written notice to VCHCP's Administrator (See Key Health Plan Contact section of this manual) containing a request for mediation and a statement describing the nature of the dispute, including the specific issue(s) involved, the cost of services involved, the remedy sought, and a declaration that the member has previously attempted to resolve the dispute with VCHCP through the established Grievance Procedure. VCHCP will agree to such reasonable requests for mediation and any request for binding arbitration (both as described below). The use of mediation services shall not preclude the right to submit a grievance or complaint to the DMHC (as described below) upon completion of mediation.

REVIEW BY THE DEPARTMENT OF MANAGED HEALTH CARE

After participating in the grievance process for at least thirty (30) days, or less if the member believes there is an imminent and serious threat to his or her health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, and the DMHC agrees there is such a threat to his or her health, or in any other case where the DMHC determines that an earlier review is warranted, the member may register unresolved disputes for review and resolution by the DMHC. Included in member communication, as appropriate, is the required language pursuant to Knox-Keene Health Care Act section 1368.02(b) and California Health and Safety Code section 1300.68(d) (4).

Arbitration

a. Mandatory arbitration is the final process for the resolution of any dispute that may arise. As a condition of enrolling with VCHCP, the member is agreeing to have any issue or dispute concerning the provision of services under the Agreement, including any issue of medical malpractice, decided by a neutral, independent arbitrator and the member is giving up his or her right to a jury or court trial.

b. Arbitration shall be conducted according to the California Arbitration Act, Code of Civil Procedures, and 1280 et seq. This will apply to any controversy, as noted above, including and not limited to the employer, subscriber, family members (whether minors or adults), the heirs-at-law or personal representatives of a subscriber or family member or network providers (including any of their agents, employees or providers).

c. Each party shall bear its/his own arbitration costs and attorney's fees, with the parties equally sharing the fees of one arbitrator.

d. The decision of the arbitrator shall be final and binding.

e. If the member seeks arbitration, he or she must send written notice to VCHCP's Administrator containing a demand for arbitration and a statement describing the nature of the dispute, including the specific issue(s) involved, the cost of services involved, the remedy sought, and a declaration that he or she has previously attempted to resolve the dispute with VCHCP through the established Grievance Procedure.

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 analyses member satisfaction information, including, but not limited to, appeals and grievance/complaint data, summary of processes and summary of disposition and outcomes. On a quarterly basis, VCHCP reports the results of these evaluations to the Member/Provider Experience Committee (MPEC), Quality Assurance and the Standing Committees which may make recommendations for change based on these results.

Application

None of the information presented in this policy pertains to provider dispute resolution. See Provider Dispute Resolution Mechanism (PDRM) document for details of this process.

Appendix C - Appeals for Medical Necessity

Purpose:

To provide a consistent plan for thorough, appropriate and timely resolution of member appeals, including pre-service, post-service, expedited and external appeals.

Definitions:

An appeal is a request to change a previous decision made by the Plan. Appeals may be requested for a denial of claims, denial of benefit, rescission of coverage or other denial or modification of coverage. Appeals may also be applicable for some complaints when a member receives an adverse decision. See Grievances/Complaints and Appeals, Appendix B.

A pre-service appeal is a request to change an adverse determination for care or services that the Plan must approve in advance of the member obtaining care or services.

A post-service appeal is a request to change an adverse determination for care or services that have already been received by the member.

An expedited appeal is a request to change an adverse determination for urgent care. Urgent care is any request for medical care or treatment with respect to which the application of the period for making non-urgent care determinations could result in the following circumstances:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

An external appeal is a request for an independent, external review of the final adverse determination made by the Plan through its internal appeal process.

Guidelines:

Members have the right to request appeals regarding modified or denied benefits and services. Ventura County Health Care Plan (VCHCP), its Plan Providers and Facilities will not discriminate against members who have chosen to file an appeal. The fact that a member submits an appeal to VCHCP will not affect in any way how 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.

Enrollees 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 Medical Director of the Plan.

The Plan does not rescind coverage with respect to an individual once the individual is covered, except in the case of an act, practice or omission that constitutes fraud, or an intentional misrepresentation of material fact as prohibited by the terms of the coverage.

VCHCP documents research, interim and final responses to the member in a fair and timely manner.

Members, member's legal guardian, conservator, relative or physician may submit an appeal.

Except for denials based on limitations or conditions contained in the Evidence of Coverage (EOC), only a licensed physician or other licensed health care professional who is competent to evaluate the specific clinical issues can modify or deny requests for services. Appeals are reviewed by a licensed physician, with appropriate expertise, who was not involved with the original decision and is not a subordinate of such individual.

A physician reviewer is available to physicians to conduct telephone discussions regarding the determinations that are made based on medical appropriateness.

An external independent medical review process is in place for members disputing a final determination made by the Plan through its internal appeal process.

An external medical review process is in place for cases involving such issues as new technology, new usage of prior technology, potential experimental or investigational protocol or uncertain effectiveness of a treatment.

The Plan has procedures in place that allow members to have continued coverage under their medical benefit pending the outcome of an internal appeal.

Procedure for Processing Appeals:

Pre-service and Post-service

With all Plan actions taken on requested services, including approvals, modifications and denials, written notification is sent to members via mail and to providers via fax, unless no fax is available, then it is sent by mail. Denial letters include the reason for the denial and the specific Utilization Management (UM) criteria or benefits interpretation, along with the application of that information to the specific patient. This notification also explains the member's appeal rights and procedure for appeals, including the right to submit written comments, documents or other information relating to the appeal and the ability to obtain specific criteria upon request.

Information regarding the appeals procedures, both internal review and independent external review, is also available in the Plan's Evidence of Coverage, sent to all eligible members at the time of enrollment and annually thereafter. Information regarding the right to independent external review includes the state's Department of Managed Health Care's (DMHC) toll-free telephone and TDD numbers as well as the department's Internet website address.

Members may register appeals with VCHCP by mail, email, fax, online, in person or by calling:

Ventura County Health Care Plan
2220 E. Gonzales Rd. Ste. 210-B
Oxnard, CA 93036

Phone: (805) 981-5050 or **(800) 600-VCHP**
Fax: 805) 981-5051
Email: vchcp.memberservices@ventura.org
Online via website: www.vchealthcareplan.org

For free Language Assistance services, including interpreter services, call VCHCP at (805) 981-5050. For TDD/TTY for the hearing impaired, call (800) 735-2929 to communicate in English or (800) 855-3000 to communicate in Spanish.

Members with limited English proficiency who call the Plan are provided with information regarding the appeal process and given assistance during the appeal process through a bilingual staff member or through a language assistance line.

A member has a right to representation at any time during the referral process. The right of the member to be represented by an attorney or any other representative, for any UM decision including an internal or external appeal, is clearly stated in the denial notification letter. This appointment must be in writing. Members can obtain an Authorized Representative form to submit by calling Member Services or visiting VCHCP in person.

The following persons may be submitted and considered as an authorized representative:

1) A friend, relative or legal representative
2) A parent of a child under 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of relevant information.
3) A court-appointed guardian, except the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of relevant information.
4) A court-appointed conservator
5) An agent under a currently effective health care proxy, to the extent provided under state law.

The Plan allows for submission of appeals up to 180 calendar days following an adverse determination. This information is included in the denial determination letter sent to the member and provider.

Upon receipt of an appeal, the information is logged into the medical management /documentation system known as QNXT and assigned a category code under call tracking. The date of the appeal is the date in which it was received by the Plan, whether or not all necessary information is available at that time. If a non-urgent appeal is received by fax outside of normal business hours, the date of receipt is the next business day. This procedure does not apply to urgent or expedited appeals which are described below. Appeals for decisions other than medical necessity or benefit coverage are handled by Member Services. Appeals for medical necessity and benefit coverage denial determinations are handled by the UM department and are forwarded from Member Services to a qualified health professional in UM. If an appropriate same or similar specialist is not available at the Plan, the case is contracted out to an independent review organization (IRO) for appeal determination.

A new determination is made regarding the reversal or maintenance of the modification or denial status within 30 calendar days of receipt of the pre-service appeal. For post-service appeals, a decision is made within 30 working days of obtaining all necessary medical information, not longer than 60 calendar days from receipt of the appeal. The only exception to this time frame would be if the member voluntarily agrees to extend the appeal time frame.

The appeal determination letter includes the specific reason(s) for the decision, in easy to understand language; reference to the benefit provision, clinical guideline or protocol upon which the decision was based; application of this information specific to the member; notification of the ability for obtaining the benefit provision, clinical guideline or protocol; as well as any documentation available relevant to the appeal, free of charge, upon request. The letter also includes the title of each reviewer for a benefit appeal or, for the medical necessity review, the title, qualifications/credentials and specialty of the clinical reviewer(s) and the title for each nonclinical reviewer and a statement of participation in the appeal process. The names of these individuals will be provided upon request.

VCHCP appeals process includes one internal appeal level. Further appeal rights are included in the notification letter, including information regarding the process to appeal to the DMHC for an Independent Medical Review as follows:

"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 (**1-805-981-5050**) 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). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online."

Note: this is the same information found in the member's EOC.

In rare instances, the Plan may refer an appeal directly to an independent review organization without conducting an internal review. However, this is only possible with the member's permission.

For appeals that are overturned, the determination letter includes the decision and the date. For any modifications of the original decision, all necessary adjustments are made including reversals of decision to modify or deny requests for services processed within VCHCP's approved time frame and financial adjustments made in the next regularly scheduled VCHCP check processing.

Determinations on behavioral health treatment appeals are delegated to OptumHealth Behavioral Solutions of California (AKA "Life Strategies"). Such delegation accepts that a licensed psychiatrist renders all denial and appeal decisions related to medical necessity determinations or a licensed psychologist can render such decisions for outpatient services rendered by non-physician practitioners.

Determination letters can be sent translated into Spanish when appropriate.

Expedited Appeals

An expedited appeal is reserved for denials of an urgent nature, when a delay in a decision might seriously jeopardize the life or health of a member. Expedited appeals may include procedures, medications, admissions, continued stay or other health care services for a member who has received emergency services, but has not been discharged from a facility. An expedited appeal is therefore not appropriate for post-service appeals.

Expedited appeals are submitted by phone or in writing, through member services. A member, the member's representative or a practitioner acting on behalf of the member may request an expedited appeal. The intake, investigation and documentation processes are the same as for pre-service and post-service appeals, however, the time frame for a decision is accelerated. Members and practitioners are notified orally or in writing of the decision in a timely manner appropriate to the severity and urgency of the condition but not longer than 72 hours, inclusive of weekends and holidays, after the appeal is received. The 72-hour timeframe begins immediately upon receipt of the request. The Plan provides for an Administrator on call, 24 hours a day/7 days a week, to respond to such requests. The practitioner is sent a confirmation of the decision within 24 hours of the decision via phone call or fax notification. The member is then sent a confirmation of the decision in writing within two (2) working days of making the decision. The written notification provides the same information as described above for pre-service and post-service appeals.

Continued Coverage

In the event of a denial, reduction or termination of previously authorized services, it is VCHCP's policy to allow members to have continued coverage of their medical benefits pending the outcome of an internal appeal. This applies, however, only to concurrent care decisions and not to requests for extension of the course of treatment beyond that already approved.

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 analyses member satisfaction information, including, but not limited to, modification and denial data, appeals data including overturns and upholds, summary of processes and summary of disposition and outcomes. VCHCP reports the results of these evaluations to the appropriate internal committee(s) such as Member/Provider Experience (MPEC), Utilization Management, Quality Assurance and the Standing Committees, which may make recommendations for change based on these results.

Appendix D - 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 these standards.

1) To ensure that the treatment rendered to members and the response to treatment is consistently documented;
2) To provide a process of quality documentation;
3) To ensure that the information is current and detailed;
4) To reflect the safe and effective transfer of care between providers;
5) To maintain confidentiality of medical information;
6) To ensure standards for the availability of medical records are appropriate to the practice site; and
7) 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:

- All the services provided by the physician provider;
- All ancillary services provided; and
- 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 the Quality Management Program Description on Confidentiality.

Policy

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

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 number & 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.

Documentation

a. Medication allergies are noted in a consistent, prominent place. Otherwise, no known allergies or the history of adverse reactions are noted.
b. Problem lists are used for members with significant illnesses and/or conditions which require ongoing monitoring.
c. The record contains a list of current medications.
d. The record contains a complete health history.
e. The record contains past medical history which includes serious illnesses, accidents, operations, and hospitalizations.
f. The record demonstrates history and physical examination that is pertinent to presenting symptoms.
g. The record demonstrates a working diagnosis that is consistent with findings.
h. The record demonstrates treatment plans that are consistent with diagnosis.
i. The record demonstrates no evidence of inappropriate risk by diagnostic or therapeutic procedures.
j. The record contains consultation notes as applicable.
k. The record demonstrates up-to-date preventive health and health maintenance screening.
l. The record demonstrates up-to-date or appropriate history related to immunizations.
m. The record includes health education. For Pediatrics, anticipatory guidance teaching is included.
n. The record demonstrates appropriate follow-up when appointments are missed.
o. The record demonstrates follow-up of unresolved problems on subsequent visits.
p. 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, accurate, detailed and 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:
    1) Patients are afforded the opportunity to approve or refuse the release of identifiable personal information, except when such release is required by law;
    2) Identifiable medical record information, when used for Utilization Management, Quality Assurance Management and case management activities is protected from disclosure;
    3) Identifiable claims information is protected from disclosure;

4) The dissemination of confidential patient information by phone, written requests, etc.

5) The requests of medical record information from regulatory agencies; and

6) 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 compliant with California regulatory requirements which 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 E - 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 laid-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 MRMIB;
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, VCHCP will provide benefits as if it were the primary group health plan, provided the member:

- assigns to VCHCP the right to receive benefits from the other group health plan;
- agrees to cooperate with VCHCP in obtaining payment from the other group health plan; and
- 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.

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 F - 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 G – Steps for Filing a AB 72 Independent Dispute Resolution

Upon submission of a complete AB 72 IDRP Application through the web-based portal, the DMHC will review the submission and then, if the submitter is a noncontracting provider, contact the health plan to confirm DMHC jurisdiction and identify the responsible payor. Once DMHC jurisdiction is confirmed and both parties to the AB 72 IDRP are clearly identified, the opposing party will have a full opportunity to submit any information and/or documents relevant to the reimbursement amount for the claim(s) at issue. After the DMHC confirms that the claim(s) dispute meets the requirements for the AB72 IDRP, the claim(s) dispute will be forwarded to the independent organization for review.

The following documents **must** be included with an IDRP Application in order for it to be processed by the DMHC:

- Claim Form(s)
- Provider Dispute Resolution (PDR) Determination Letter(s)
    - Note: If a provider attempted PDR but did not receive an acknowledgment letter or determination letter from the payor and at least 45 business days have passed since the date of receipt of the provider dispute, the provider may submit dated proof of the PDR attempt in lieu of a PDR determination letter.
- Explanation(s) of Benefits or Remittance Advice

All documents relevant to the claim(s) dispute must be submitted in Portable Document Format (.pdf). Parties will not have an opportunity to revise their AB 72 IDRP Application after it is submitted. It is each AB 72 IDRP participant's responsibility to redact all proprietary, confidential, or protected health information that should not be viewed by the DMHC, the independent organization, or parties to the AB 72 IDRP. Additionally, it is each AB 72 IDRP participant's responsibility to redact all identifying information relating to patient claims that are not in dispute from documents uploaded to the AB 72 IDRP portal.

AB 72 IDRP portal: https://ab72idrp.maximus.com/my.policy

Appendix H - Glossary

Advance 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

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. VCHCP will adjudicate complete claims.

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 at 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, which 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 form.

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. A member, member representative, or physician on behalf of the member may request an expedited grievance.

Expedited Initial Determination

Prior authorization requests 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 (FFS)

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 (HIPAA) 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 that 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.