VENTURA COUNTY
HEALTH CARE PLAN
A Department of Ventura County Health Care Agency

2025 PROVIDER SERVICES GUIDE

This is only a summary. Please consult the Provider Operations Manual or call the Plan directly for more detailed information at Member & Provider Services (805) 981-5050 or (800) 600-8247.

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CONTACT INFORMATION:

REGULAR BUSINESS HOURS ARE:

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

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

Provider Services Email:

VCHCP.ProviderServices@ventura.org

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

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

VCHCP 24-Hour Administrator Access for emergency provider at:

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

VCHCP Utilization Management Staff

Regular Business Hours are:
Monday - Friday, 8:30 a.m. to 4:30 p.m.

- Phone: (805) 981-5060 • Fax: (805) 658-4556

Provider Directory

The Ventura County Health Care Plan's Provider Directory is located online at vchealthcareplan.org/members/physicians.aspx

The Provider Directory is updated on a **weekly basis**. To request a printed copy of the Provider Directory, either...

- Email Provider Services at VCHCP.ProviderServices@ventura.org
- Call VCHCP at (805) 981-5050 or (800) 600-8247
- Call or Email our Provider Services Administrator at: Noemi Solomon
  Noemi.Solomon@ventura.org
  (805) 981-5137

Provider Toolkit

The Provider Toolkit can be found on the Provider Connections page on the VCHCP website:
vchealthcareplan.org/providers/providerIndex.aspx

The toolkit includes two educational documents created by the Health Industry Collaboration Effort (HICE) to promote health equity, including cultural competence, bias, diversity, and inclusion.

There is also a link to the Knowledge, Evaluation and Research (KER) website: carethatfits.org/, which draws on user-centered design to create conversation tools for patients and clinicians to use together to make treatment choices in line with patient values and preferences.

Ventura County Health Care Plan (VCHCP) Website

https://www.vchealthcareplan.org/

Provider Resources

The following resources can be found by visiting the ***"Provider Connection"*** page on VCHCP's website:

- Health Services Approval Process
- Direct Referral Guidelines
- Medical Policies
- Provider Operations Manual
- Preferred Medication List
- & much more…

Member Plan Information

The following resources can be found by visiting the ***"For Members"*** page on VCHCP's website:

- Benefit Information (such as covered services and copays)
- Pharmacy Information
- Language Assistance
- Grievance and Appeals
- Behavior Health and Substance Use
- Case Management and Disease Management
- & much more…

Provider Directory

The full list of participating providers can be found by visiting the ***"Find a Provider"*** page on VCHCP's website: https://www.vchealthcareplan.org/members/physicians.aspx

LANGUAGE & COMMUNICATION
ASSISTANCE

It is important for members to have good communication with VCHCP and their providers.

If English is not their first language, VCHCP provides interpretation services and translations of certain written materials.

- **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 to arrange for interpreter services. This should be done in advance of the member's appointment, as to not delay care.**
- Members can also ask for language services, by calling VCHCP at (805) 981-5050 or (800) 600-8247. They may obtain language assistance services, including oral interpretation and translated written materials, free of charge and in a timely manner. Members may obtain interpretation services free of charge in English and the top 15 languages spoken by limited-English proficient individuals in California as determined by the State of California Department of Health Services.
- For members who are deaf, hard of hearing or have a speech impairment, they may also receive language assistance services by calling TDD to Voice (800) 735-2929; Voice to TDD (800) 735-2922 for English or (800) 855-3000 for Spanish.
- If members have a preferred language, they may notify us of their personal language needs by calling VCHCP at (805) 981-5050 or (800) 600-8247 or by completing the Language/Ethnicity Questionnaire.
- Interpreter services will be provided to the member, if requested and arranged in advance, at all medical appointments.

If members have a disability and need free auxiliary aids and services, including qualified interpreters for disabilities and information in alternate formats, including written information in other formats, they may request that the information be provided to them free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity for them to participate.

Direct Specialty Referrals

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

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

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

Electronic Claims Submission

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

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

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

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

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

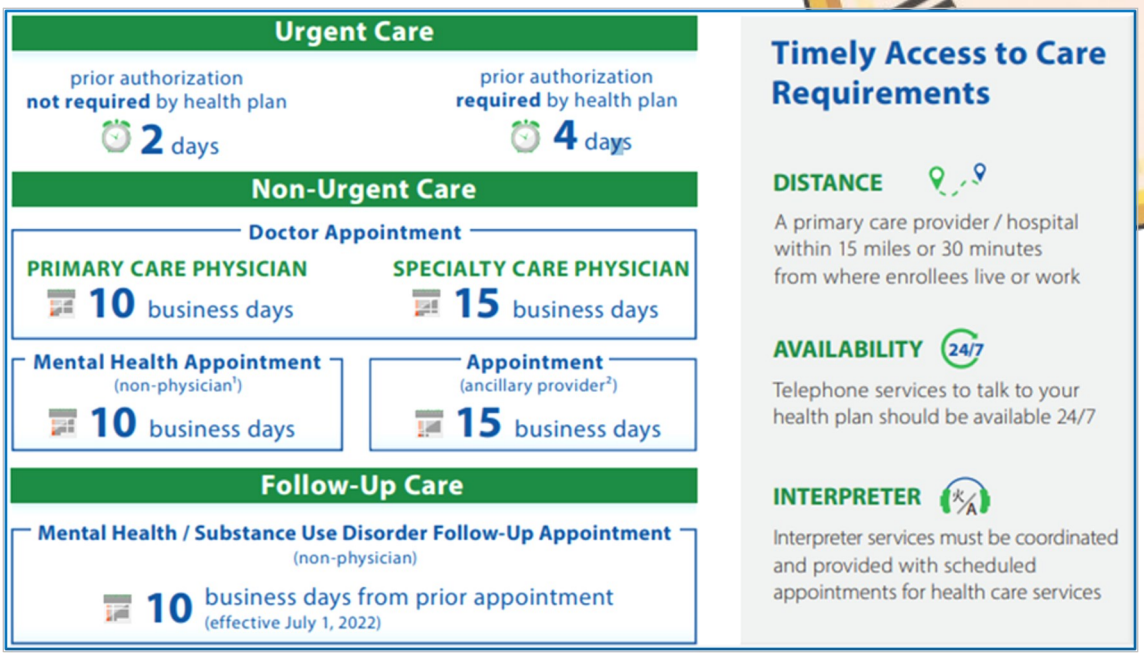
Paper Submission

In order for the Plan to process paper claims as quickly, accurately, and efficiently as possible, providers should submit a properly completed "Centers for Medicare and Medicaid (CMS) 1500 Form" or its successor as adopted by the National Uniform Claim Committee (NUCC). For hospital and other facility providers the UB-04 (CMS 1450) is used. The Official UB-04 Data Specification Manual is the official source of UB-04 billing information as adopted by the National Uniform Billing Committee (NUBC). Please send claims to:

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

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

TIMELY ACCESS REQUIREMENTS



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

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.

Standards Include:

TYPE OF CARE	WAIT TIME OR AVAILABILITY
Emergency Services	Immediately, 24 hours/day, 7 days/week
Urgent Need—No Prior Authorization Required	Within 48 hours
Urgent Need—Requires Prior Authorization	Within 96 hours
Primary Care	Within 10 business days
Specialty Care	Within 15 business days
Ancillary services for diagnosis or treatment	Within 15 business days
Mental Health and Substance Use Disorder including nonurgent follow-up appointments with nonphysician mental health care or substance use disorder providers	Within 10 business days
Phone wait time for triage or screening by the provider office	Not to exceed 30 minutes
Wait time for enrollees to speak with a qualified Plan representative during business hours	Not to exceed 10 minutes

TREATMENT AUTHORIZATION REQUESTS (TAR) PROCESS

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

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

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

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

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

Prescription Drug Prior Authorization *or* Step Therapy Exception Request Form

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

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

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

SPECIALTY *Medication Request* & ACCREDO

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

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

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

Submitting an External Exception Review Request…

for the denial of request for Step Therapy Exception,
Formulary Exception, and Prior Authorization for a medication

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 the prescriber to process the External Exception Review Request.
- The Plan sends the 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 the 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.

GRIEVANCE & APPEAL PROCESS

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 grievance/ complaint and appeal system for the Plan Members to file a grievance. We endeavor to assure our members of their rights to voice complaints and appeals, and to expedite resolutions.

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. Members may register complaints with VCHCP by calling, writing, or via email or fax or by using the on-line form available on the VCHCP website:

Ventura County Health Care Plan
2220 E. Gonzales Rd. Ste. 210-B
Oxnard, CA 93036
Phone: (805) 981-5050 Fax: (805) 981-5051
Email: VCHCP.Memberservices@ventura.org
Website: vchealthcareplan.org

The Plan shall provide written acknowledgment of a Member's grievance within five (5) days of receipt. The Plan shall provide a written response to a grievance within thirty (30) days. 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. This also applies to grievances for terminations for non-renewals, rescissions, and cancellations. The Plan shall provide a written statement on the disposition or pending status of a case requiring an expedited review no later than three days from receipt of the grievance.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (**1-805-981-5050**) or (**1-800-600-8247**) and for hearing impaired members: TDD to Voice (**1-800-735-2929**); Voice to TDD (**1-800-735-2922)** for English or (**1-800-855-3000**) for Spanish 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 (**dmhc.ca.gov**) has complaint forms IMR application forms and instructions online.

Standards for Members' Rights and 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:

1. Members have a right to receive information about VCHCP, its services, its Practitioners and Providers, and Members' Rights and Responsibilities.

2. Members have a right to be treated with respect and recognition of their dignity and right to privacy.

3. Members have a right to participate with Practitioners and Providers in decision making regarding their health care.

4. Members have a right to a candid discussion of treatment alternatives with their Practitioner and Provider regardless of the cost or benefit coverage of the Ventura County Health Care Plan.

5. Members have a right to make recommendations regarding VCHCP's Member Rights and responsibility policy.

6. Members have a right to voice complaints or appeals about VCHCP or the care provided.

7. 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.

8. Members have a responsibility to follow the plans and instructions for care that they have agreed upon with their Practitioners and Providers.

9. Members have a responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

2220 E Gonzales Road, Suite 210B • Oxnard, CA 93036 • TEL: (805) 981-5050 or (800) 600-8247 • FAX: (805) 981-5051
vchealthcareplan.org