

PROVIDER NEWSLETTER

SUMMER ISSUE • JUNE 2024

Featured in this issue

TIMELY ACCESS
Requirements 3

PROVIDER
Operations Manual 3

HEDIS
Cheat Sheet 16

We're Here for You 24/7!

The Ventura County Health Care Plan (VCHCP) understands that providers often need to contact the Health Plan outside of regular business hours. VCHCP always has someone on-call to speak with you. For urgent prior authorizations, information on contracted tertiary hospitals, coordination of hospital-to-hospital transfers (including air transports) or other urgent Health Plan related matters, please contact VCHCP 24-hours per day, 7 days a week at (805) 981-5050 or toll free at (800) 600-8247 and our answering service will contact an on-call clinical staff member to help you.



VENTURA COUNTY
HEALTH CARE PLAN
SUMMER ISSUE | JUNE 2024

CONTACT INFORMATION

Provider Services Email:
VCHCP.ProviderServices@ventura.org
(Email is responded to Monday - Friday,
8:30 a.m. - 4:30 p.m.)

VENTURA COUNTY
HEALTH CARE PLAN

24-hour Administrator access
for emergency provider at:
(805) 981-5050 or (800) 600-8247

REGULAR BUSINESS
HOURS ARE:

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

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

VCHCP UTILIZATION
MANAGEMENT STAFF

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

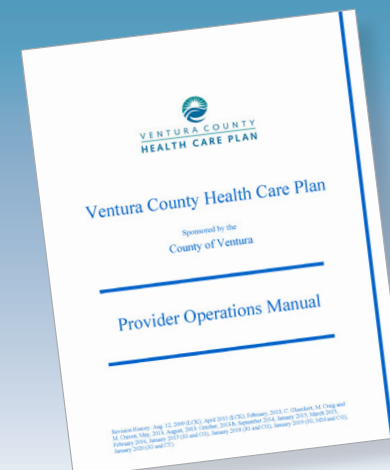
- Phone: (805) 981-5060

GRAPHIC DESIGN &
PRINTING:

GSA Business Support/Creative Services

contents

Provider Operations Manual Updated	3
Patient Emergency & Provider After Hours Contact	3
Timely Access Requirements	3
Introducing Ventura County Health Care Plan's Provider Toolkit	4
Milliman Care Guidelines	5
Medical Policy Updates	5
Clinical Practice Guidelines	5
Education Materials	5
Referral & Prior Authorization Process & Services Requiring Prior Authorization	6
Standing Referrals	6
Direct Specialty Referrals	7
TAR Process	8
VCHCP Offers Assistance to Patients Struggling with Smoking Cessation	9
Preventive Health Guidelines	9
Promoting Patient Health	10
Biomarker Testing	11
Case Management	12
Complex Case Management (CCM)	13
New Medical Technology	13
Improving Asthma Control: Evidence-Based Tips for Healthcare Providers	14
Annual Asthma and Diabetes Disease Management Mass Mailing	15
HEDIS Cheat Sheet 2023-2024	16
Health Services Accomplishments for 2023-2024	20
VCHCP 2024 Affirmative Statement Regarding Utilization Related to Incentive*	20
HEDIS Tips & Information	21
Submitting Exception Requests to the Preferred Drug List	22
Pharmacy Updates & Deletions	23
Formulary Web Posting	23
Attention: VCHCP PCP Primary Care Practitioners!	24
Autism Spectrum Disorder Ventura County Health Care Plan's Autism Case Management Program	25
VCHCP Resources for Member Behavioral Health and Substance Abuse	26
Accessing Services for Behavioral Health	26
Optum Case Management Referral for Members with Social Determinants of Health	26
Treatment for Individuals with Substance Abuse Order	27
Treatment Support for Opioid Use Disorders	28
Follow-up Care After Discharge	29
Antidepressant Medication Screening & Management	30
Important Information about Coordination of Care (COC)	32
Standards for Members' Rights & Responsibilities	33
VCHCP Network Updates	34
Provider Satisfaction Survey	35



PROVIDER OPERATIONS MANUAL Updated

The 2024 version of the Provider Operations Manual is now available on the Plan's website.

To request a copy of the Provider Operations Manual, please email Provider Services at VCHCP.ProviderServices@ventura.org or visit the Plan's website at: vchealthcareplan.org.

- **CLICK ON:** Provider Connection
- **CLICK ON:** Provider Relations
- **CLICK ON:** Provider Operations Manual

Patient Emergency & Provider AFTER HOURS CONTACT

Ventura County Medical Center Emergency Room

300 Hillmont Avenue,
Ventura, CA 93003

(805) 652-6165 or
(805) 652-6000

Santa Paula Hospital

A Campus of Ventura
County Medical Center

825 N Tenth Street
Santa Paula, CA 93060

(805) 933-8632 or
(805) 933-8600

Ventura County Health Care Plan

on call Administrator
available 24 hours per
day for Emergency
Providers

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

THE NURSE ADVICE LINE 1-800-334-9023

Available 24 hours a day, 7 days a week for member questions regarding a general health topic or specific medical questions, including deciding whether to seek care for a condition.

There is also a link on the member website: vchealthcareplan.org/members/memberIndex.aspx that will take Members to a secured email where they may send an email directly to the advice line. The nurse advice line will respond within 24 hours.



To speak with VCHCP UM Staff, please call The Ventura County Health Care Plan at the numbers below:

QUESTIONS? CONTACT US:
MONDAY - FRIDAY, 8:30 a.m. to 4:30 p.m.

Phone: (805) 981-5060 or toll-free (800) 600-8247
FAX: (805) 981-5051, vchealthcareplan.org

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

Ventura County Health Care Plan 24-hour
Administrator access for emergency providers:
(805) 981-5050 or (800) 600-8247

Language Assistance - Language Line Services:
Phone (805) 981-5050 or toll-free (800) 600-8247

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.

Type of Care	Wait Time or Availability
Emergency Services	Immediately, 24 hours a day, 7 days a 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

Introducing VENTURA COUNTY HEALTH CARE PLAN'S PROVIDER TOOLKIT FOR:

Better Communication, Better Care, Provider Tools to Care for Diverse Populations



This tool was created by a nation-wide team of healthcare professionals who, like you, provide high quality, effective, and compassionate care to their patients. Awareness of differences in individual belief and behavior, changes in demographics and new legal mandates, providers are constantly presented with new challenges in order to deliver adequate and culturally sensitive health care to a diverse patient population. The material in this tool kit will provide you with resources and information to effectively communicate and understand our diverse patient populations. The tool kit also provides many useful instruments and aids to help with specific operational needs that can arise in your office or facility.

Explore Now: vhealthcareplan.org/providers/BetterCommunication.aspx

Gender Inclusive, Sensitive Language

This document will help you in the design of written materials to be both inclusive, sensitive, and compliant with the National Culturally and Linguistically Appropriate Service (CLAS) Standards and Section 1557 of the Affordable Care Act (ACA). Using gender neutral and culturally sensitive wording when creating any documents-whether for staff, members, providers, or the community is best practice, aligns with regulations and it fosters inclusivity. The lists in this tool kit will assist when writing or reviewing documents that include exclusionary and inclusive phrases or words that have been found in materials.

Explore Now: vhealthcareplan.org/providers/GenderInclusiveCommunication.aspx

Care That Fits

For care to be effective it must respond well to a patient's situation. To do so, care must be biomedically correct with a sound argument backing its implementation. In addition, it should be consistent with the patient's personal values, desires, and goals. Lastly, care should be feasible given the resources that can be mobilized and the opportunity costs of doing so. To fit, such care must be tailored so that it makes intellectual, emotional, and practical sense to this patient. This tool will provide you with tips to help patients receive the care that each one needs and fits them.

Explore Now: vhealthcareplan.org/providers/CareThatFits.aspx

The Provider Toolkit can be found on the
Provider Connection page of VCHCP's website vhealthcareplan.org

MILLIMAN CARE Guidelines

VCHCP Utilization Management uses Milliman Care Guidelines 28th Edition, 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 Milliman Care Guidelines 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:

vhealthcareplan.org/providers/medicalPolicies.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.**

Medical Policy Updates

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

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

Clinical Practice Guidelines

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 links for providers:

- Clinical Practice Guidelines
- 2 medical conditions: Asthma & Diabetes
 - [Joslin Diabetic Center and Joslin Clinic](https://www.joslin.org)
 - American Diabetes Associates (ADA) at diabetes.org
 - [National Asthma Education and Prevention Program Expert Panel Report 3, Guidelines for the Diagnosis and Management of Asthma](https://www.nhlbi.nih.gov/asthma)
- 1 behavioral health conditions: Depression
 - [American Psychiatric Association](https://www.psychiatry.org)
- Preventive guidelines for all age group
 - [The Institute for Clinical Systems Improvement \(ICSI\)](https://www.instituteofmedicine.org/clinical-systems-improvement)
 - [U.S. Preventive Services Task Force \(USPSTF\)](https://www.uspreventiveservicestaskforce.org)
 - [Advisory Committee on Immunization Practices \(ACIP\)](https://www.acip.org)
- [Non-profit Professional Society, Standards of Care developed by the World Professional Association for Transgender Health \(WPATH\)](https://www.wpath.org)

Link to be used:

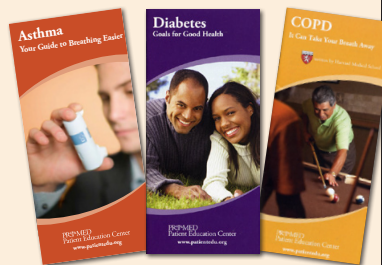
vhealthcareplan.org/providers/medicalPolicies.aspx

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

EDUCATION MATERIALS

To access the Plan's useful and current educational materials, please click on this link:

[VCHCP - Members - Health Education Information \(vhealthcareplan.org\)](https://vhealthcareplan.org/members/health-education-information)

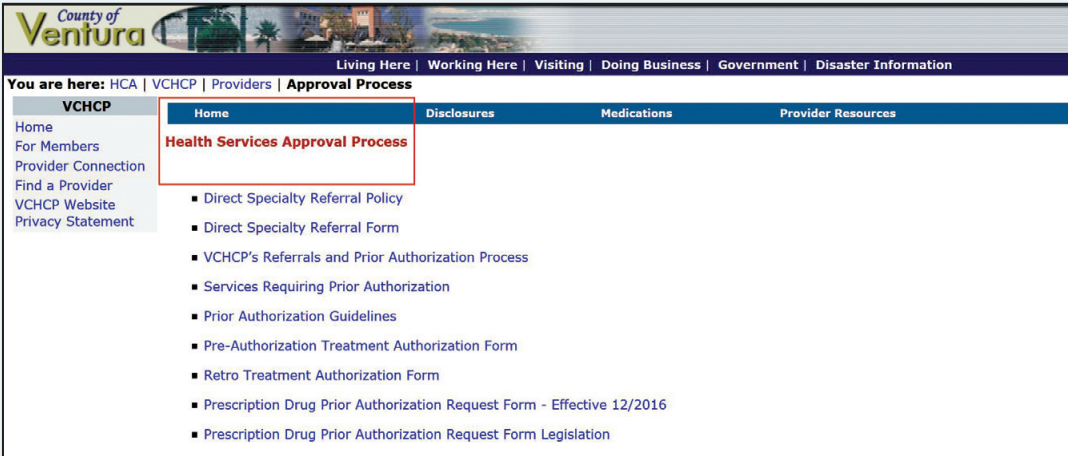


Referral & Prior Authorization Process & Services Requiring Prior Authorization

Providers have the ability to review how and when to obtain referrals and authorization for specific services.

Go to vhealthcareplan.org/providers/hsApprovalProcess.aspx. 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.

To ensure that requests for referral and prior authorizations are reviewed in a timely manner, Providers must submit TARs to the Plan’s UM department promptly.



QUESTIONS? Call Member Services at (805) 981-5050

Standing Referrals

A standing referral allow members to see a specialist or obtain ancillary services, such as lab, without needing new referrals from their primary care physician for each visit. Members may request a standing referral for a chronic condition requiring stabilized care. The Primary Care Physician will decide if a standing referral is needed when the request meets the following guidelines:

A standing referral is limited to 6 months, but can be reviewed for medical necessity as needed, to cover the duration of the condition. If members change primary care physicians or clinics, member will need to discuss their standing referral with their new physician. Additional information regarding Standing Referrals is located on our website: vhealthcareplan.org/providers/docs/medpolicies/StandingReferralsToSpecialists.pdf or by calling Member Services a (805) 981-5050 or (800) 600-8247.

- A standing referral may be authorized for the following conditions when it is anticipated that the care will be ongoing:
- Chronic health condition (such as diabetes, COPD etc.)
 - Life-threatening mental or physical condition
 - Pregnancy beyond the first trimester
 - Degenerative disease or disability
 - Radiation treatment
 - Chemotherapy
 - Allergy injections
 - Defibrillator checks
 - Pacemaker checks
 - Dialysis/end-stage renal disease
 - Other serious conditions that require treatment by a specialist



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 this form.

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

Appointments to specialists when a member receives a direct referral from their PCP

should be made either by the member or by the referring doctor. Make sure to communicate with the member about who is responsible for making the appointment.



Appointments are required to be offered within a specific time frame, unless the doctor has indicated on the referral form that a longer wait time would not have a detrimental impact on the member's health. Those timeframes are: Non-urgent within 15 business days, Urgent within 48-96 hours.

If you feel that your patient is not able to get an appointment within an acceptable timeframe, please contact the Plan’s Member Services Department at (805) 981-5050 or (800) 600-8247 so that we can make the appropriate arrangements for timeliness of care.

THE DIRECT REFERRAL POLICY CAN ALSO BE ACCESSED AT:
vhealthcareplan.org/providers/docs/medpolicies/DirectSpecialtyReferral.pdf
To request to have a printed copy of the policy mailed to you, please call Member Services at the numbers listed above.

TAR Process

When a Treatment Authorization Request (TAR) has been “pending for additional information” it means that VCHCP needs more information from the Provider to complete the TAR review process.
THE PROCESS IS AS FOLLOWS:

- 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 pending, b) what information is missing, and c) will provide for up to 45 calendar days (for routine TAR requests) for the requested additional information to be submitted to VCHCP. Per NCQA standards, a TAR can only be pending 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:

“PENDING FOR ADDITIONAL INFORMATION”

- ◇ 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.
- ◇ 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.
- ◇ If written notes are submitted, please be sure they are legible.
- In addition to faxing pend letters for needed additional information to providers, the Plan’s UM began sending messages through Cerner to inform VCMC requesting provider of pending request and clinical information needed by the Plan to make a medical necessity decision. For Non-VCMC providers, a phone call is placed to the requesting provider of the pending request and clinical information needed by the Plan.
- The Plan’s pend letter was updated with an “Alert” to providers that clinical information is needed.

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: vhealthcareplan.org/providers/docs/preAuthorizationTreatmentAuthorizationForm.pdf

VCHCP OFFERS Assistance to Patients Struggling with Smoking Cessation

As valued healthcare partners, we wanted to remind you about an important program that could be beneficial to your patients who are smokers or tobacco users.

At Ventura County Health Care Plan (VCHCP), we are committed to improving the health and well-being of our members. That’s why we offer education and support materials on the VCHCP Member Website. Patients can access these materials by visiting vhealthcareplan.org/members/healthEducationInfo.aspx.

The California Department of Public Health funded a program called **KickIt California** which provides one-on-one support from caring, trained professionals who are dedicated to helping patients quit smoking. They offer a range of helpful tools, including telephone counseling, self-help materials, a mobile app, and a text messaging program. Services are free. Patients can enroll in the program by calling Kick It California at **(800) 300-8086** or by visiting the website at kickitca.org.

In addition, Ventura County Public Health Department also offers a Tobacco Education and Prevention Program. Patients can contact Public Health directly at (805) 201-STOP (7867) or via email at Callitquits@ventura.org to learn more about their program.

At VCHCP, we are committed to helping your patients succeed in quitting smoking. If you require any further assistance, please do not hesitate to contact our Health Services Department at (805) 981-5060, and we will return your call within 24 hours.

Thank you for your continued partnership in improving the health of our community.



PREVENTIVE HEALTH GUIDELINES

The 2023-2024 Preventive Health Guidelines is an excellent resource where Providers can find immunization schedules, preventive health screening information, and an adult preventive care timeline.

The Preventive Health Guidelines include information from VCHCP, US Preventive Services Task Force (USPSTF), Centers for Disease Control (CDC), and the Agency for Healthcare Research and Quality (AHRQ) and are updated annually. Providers and members are given access to the Preventive Health Guidelines online at: vhealthcareplan.org/members/docs/healthEducationInfo/preventiveHealthGuidelinesCommercial.pdf

Please contact Member Services at (805) 981-5050 if you need assistance or hard copies.

Promoting Patient Health:

Focus on BMI-Nutrition Counseling, Childhood Immunizations, Mammograms, and Appropriate Antibiotic Treatment

As the healthcare landscape evolves, it is imperative that we keep up with the latest guidelines and recommendations for our patients' health. In this issue of our provider newsletter, we will focus on BMI-nutrition counseling, childhood immunizations, mammograms, and inappropriate antibiotic treatment for acute bronchitis/bronchiolitis.

BMI-NUTRITION COUNSELING:

Obesity is a growing epidemic in our society, and it is a significant risk factor for chronic diseases such as diabetes, heart disease, and hypertension. As healthcare providers, we must make every effort to prevent and manage obesity in our patients. One effective approach is through BMI-nutrition counseling.

BMI (body mass index) is a measure of body fat based on height and weight. It is a useful tool to screen for overweight and obesity. When counseling patients on nutrition, it is essential to focus on healthy eating habits, portion control, and physical activity. Encourage your patients to eat a balanced diet that includes fruits, vegetables, whole grains, lean protein, and healthy fats. Additionally, patients should be encouraged to limit their intake of processed foods, sugary drinks, and saturated fats.

CHILDHOOD IMMUNIZATIONS:

Childhood immunizations are critical in preventing infectious diseases and keeping our children healthy. According to the Centers for Disease Control and Prevention (CDC), vaccination rates have decreased during the COVID-19 pandemic. As healthcare providers, we must remind parents and guardians of the importance of childhood immunizations.

It is essential to follow the recommended immunization schedule for children, which includes vaccinations against diseases such as measles, mumps, rubella, chickenpox, polio, and whooping cough. These vaccines are safe and effective in preventing these diseases, and they are required for school entry in California.

In conclusion, as healthcare providers, we play a crucial role in promoting the health and well-being of our patients. By focusing on BMI-nutrition counseling, childhood immunizations, mammograms, and inappropriate antibiotic treatment for acute bronchitis/bronchiolitis, we can make a significant impact on the health of our patients. Thank you for all that you do.

REFERENCES:

"Promoting Patient Health: Focus on BMI-Nutrition Counseling, Childhood Immunizations, Mammograms, and Appropriate Antibiotic Treatment"

"The Provider's Role in Preventing Obesity, Promoting Immunizations, and Reducing Antibiotic Overuse"

"Best Practices for BMI-Nutrition Counseling, Childhood Immunizations, Mammograms, and Antibiotic Treatment in California Health Plans"

"Preventing Chronic Disease and Improving Health Outcomes: A Guide for Healthcare Providers"

"The Importance of Evidence-Based Practices in BMI-Nutrition Counseling, Childhood Immunizations, Mammograms, and Antibiotic Treatment"

MAMMOGRAMS:

Breast cancer is the most common cancer in women worldwide. Mammograms are an effective screening tool for breast cancer, and they can detect breast cancer at an early stage when it is most treatable. The American Cancer Society recommends that women with an average risk of breast cancer start getting mammograms at age 40.

As healthcare providers, we must encourage our female patients to get regular mammograms. We should also educate them on breast self-exams and the signs and symptoms of breast cancer.

INAPPROPRIATE ANTIBIOTIC TREATMENT FOR ACUTE BRONCHITIS/BRONCHIOLITIS (AAB):

Acute bronchitis/bronchiolitis is a common respiratory illness that is often caused by a viral infection. Antibiotics are not effective in treating viral infections, yet they are often prescribed inappropriately for acute bronchitis/bronchiolitis. This can lead to antibiotic resistance, which is a growing public health concern.

As healthcare providers, we must avoid the inappropriate use of antibiotics for acute bronchitis/bronchiolitis. Instead, we should focus on symptomatic relief and supportive care. We can prescribe bronchodilators, cough suppressants, and inhaled steroids for symptom relief.

BIOMARKER TESTING



VCHCP covers biomarker testing and does not require prior authorization

(as mandated by SB535) for an enrollee with advanced or metastatic stage 3 or 4 cancer; and cancer progression or recurrence in the enrollee with advanced or metastatic stage 3 or 4 cancer, effective July 1, 2022. Providers must provide applicable cancer or history of cancer diagnosis codes in the primary/principal position on the claim:

- **Cancer diagnosis codes: C00 through C96.Z**
- **History of cancer diagnosis code: Z85 through Z85.9**

VCHCP covers biomarker testing as mandated by SB496. This bill would require a health care service plans on or after July 1, 2024, to provide coverage for medically necessary biomarker testing, as prescribed, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition to guide treatment decisions. Prior authorization is required.

The bill requires the Plans, on or after July 1, 2024, to cover biomarker tests that meet any of the following:

- **A labeled indication for a test that has been approved and cleared by the FDA or is an indicated test for an FDA-approved drug.**
- **A national coverage determination made by the Centers for Medicare and Medicaid Services.**
- **A local coverage determination made by a Medicare Administrative Contractor for California.**
- **Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.**

PROCEDURE

1. SB 535 Biomarker for advanced cancer includes CPT code range of 81400-81408.
2. SB 496 Biomarker includes but is not limited to these CPT codes:

81206, 81207, 81208 - BCR/ABL1

81270 - JAK2 (p.V617F)

81479 - CALR

81219 - CALR (exon 9)

81479 - CSF3R

81175, 81176 - ASXL1

81479 - TET2

81236, 81237 - EXH2

81351, 81352, 81353 - TP53

81273 - KIT (including p.D816V)

81517 - Liver disease (liver fibrosis), analysis of 3 biomarkers (HA, PIIINP, TIMP-1)

0062U - IgG and IgM analysis of 80 biomarkers of systemic lupus erythematosus in serum

0310U - Analysis of 3 biomarkers (NT-proBNP, C-reactive protein and T-uptake) for Kawasaki disease in plasma specimen

3. Please refer to the Plan's Utilization Management Policy & Procedure: Treatment Authorization Request Authorization Process and Timeline Standards to address compliance with Health and Safety Code Section 1363.5. The Plan's Member and Provider Newsletters direct providers and members to the Plan's website on how to access Plan's criteria/guidelines and policies.

Click Treatment Authorization Request: [Authorization Process and Timeline Standards for further information.](#)

4. Please refer to the Plan's Utilization Management Policy for Appeals to address compliance with Health and Safety Code Section 1367.667. The Plan's Member and Provider Newsletters direct providers and members to the Plan's website on how to access Plan's criteria/guidelines and policies.

Click here to learn more about the [UM Management Policy for Appeals.](#)

Case Management

Case Management is a process designed to coordinate services more efficiently, 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 a program online on the Member page at vchealthcareplan.org/members/requestAssistanceForm.aspx.

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.

Complex Case Management (CCM)

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, facilitation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

VCHCP's CCM program is an opt-out program, and all eligible members have the right to participate or decline participation. Verbal consent is obtained prior to formally enrolling the member into the Complex Case Management Program. Members who are identified with the following situations include but are not limited to Transplants, ESRD, Traumatic Brain Injuries and High-Risk Diabetics. Referrals to CCM can be through VCHCP medical management staff, hospital discharge planners, members or caregivers, and practitioners.

For a detailed information regarding complex case management, please refer to the policy and procedure located in the provider website: vchealthcareplan.org/members/docs/VCHCPComplexCaseManagementPolicyAnd%20Procedure.pdf. Or you can call the VCHCP's Case Management Department at (805)981-5060.



DID YOU KNOW that VCHCP has a policy in place to evaluate any new technology or new applications of existing technology on a case by case basis? There are four categories we look at – medical procedures, behavioral health procedures, pharmaceuticals (medications) and medical devices. VCHCP's Medical Director, or designee, evaluates new technology that has been approved by the appropriate regulatory body, such as the Food and Drug Administration (FDA) or the National Institutes of Health (NIH). Scientific evidence from many sources, specialists with expertise related to the technology and outside consultants when applicable are used for the evaluation. The technology must demonstrate improvement in health outcomes or health risks, the benefit must outweigh any potential harm and it must be as beneficial as any established alternative. The technology must

also be generally accepted as safe and effective by the medical community and not investigational. For help with new medication evaluations, the Plan looks to our Pharmacy Benefit Manager, Express Scripts, for their expertise. For new behavioral health procedures, the Plan uses evaluations done by our Behavioral Health delegate, OptumHealth Behavioral Solutions of California (also known as Life Strategies). Once new technology is evaluated by the Plan, the appropriate VCHCP committee reviews and discusses the evaluation and makes a final decision on whether to approve or deny the new technology. This final decision may also determine if any new technology is appropriate for inclusion in the plan's benefit package in the future.

For any questions, please contact the VCHCP Utilization Management Department at (805) 981-5060.

Improving Asthma Control: Evidence-Based Tips for Healthcare Providers



Asthma is a chronic respiratory disease that affects millions of people worldwide. In California alone, more than 3 million people have been diagnosed with asthma, making it a significant public health concern. As healthcare providers, it's crucial to understand how to effectively manage asthma to improve patients' quality of life and reduce the risk of exacerbations. Here are some evidence-based tips and resources to help you manage asthma:

ENSURE ACCURATE DIAGNOSIS:

Accurate diagnosis is critical for effective asthma management. Confirming the diagnosis requires taking a detailed medical history, performing a physical examination, and conducting lung function tests. It's also essential to rule out other respiratory conditions that may mimic asthma symptoms, such as chronic obstructive pulmonary disease (COPD) or bronchitis.

DEVELOP AN ASTHMA ACTION PLAN:

An asthma action plan outlines the patient's symptoms, triggers, and medications, and what to do in case of an asthma attack. It's an essential tool for self-management and can significantly reduce the risk of exacerbations. Encourage patients to have a written asthma action plan that they can follow at home and share with their caregivers.

EDUCATE PATIENTS ON PROPER MEDICATION USE:

Asthma medications include quick-relief and long-term control medications. It's essential to educate patients on proper medication use, including the correct inhaler technique, dosage, and frequency. Patients should also be aware of potential side effects and when to seek medical attention.

IDENTIFY AND MANAGE TRIGGERS:

Asthma triggers can vary from person to person and may include allergens, air pollution, exercise, stress, and cold weather. Identifying and managing triggers can significantly improve asthma control. Encourage patients to avoid triggers whenever possible and take steps to minimize exposure.

REFERENCES:

Global Initiative for Asthma (GINA). Global strategy for asthma management and prevention. Updated 2021. ginasthma.org/wp-content/uploads/2021/04/GINA-Main-Report-2021-V2-WMS.pdf

American College of Allergy, Asthma & Immunology. Asthma action plan. Accessed April 24, 2023. acaai.org/asthma/asthma-treatment/asthma-action-plan

National Asthma Education and Prevention Program, Third Expert Panel on the Diagnosis and Management of Asthma. Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. Bethesda (MD): National Heart, Lung, and Blood Institute (US); 2007 Aug. Available from: ncbi.nlm.nih.gov/books/NBK7232/

Centers for Disease Control and Prevention. Asthma triggers. Updated March 3, 2022. cdc.gov/asthma/triggers.html

Annual Asthma and Diabetes Disease Management MASS MAILING



VCHCP will be sending office managers and medical directors a list of patients affiliated with your clinic or physician group who are Ventura County Health Care Plan (VCHCP) members enrolled in the Disease Management Program.

Members are eligible to participate in this program based on a review of available claims information submitted to us by one or more of their doctors or health care professionals that indicates these members have been identified as having diabetes or asthma. This is a program designed to help your patients better understand their condition, update them on new information about their condition, and provide them with assistance from health professionals to help them manage their health. The program is designed to reinforce your treatment plan with the patient.

The program components include mailed educational materials to help your patients understand and manage medications prescribed by you, how to effectively plan visits to see you, information to help support your treatment plans for the patient,

telephonic education (health coaching) from our nurses and other health care staff to help them understand how to best manage their condition, and care coordination of the health care services they receive.

The program is voluntary: the members are automatically enrolled when we identify them as diabetics and/or asthmatics.

Members can opt out at any time.

Please note that included on the list that we will be sending are patients who may be missing diabetes-related and preventive care services based on our claim records. This information is included to assist you with identifying what services the patients may need to maintain their health. We encourage you to have

your staff contact the patients and work with the Primary Care Physicians to facilitate these services if the patients have not received the services at this time.

Again, if you feel that a member already received care but was still noted as a care gap, you may fax supplemental data information (medical records) to (805) 981-5061.

If you would like to refer patients who are VCHCP members but are not in the program, please contact us at (805) 981-5060. Members can also self-refer to the program online on the Member page at vchealthcareplan.org/members/requestAssistanceForm.aspx

If you have any questions or concerns regarding the Disease Management Program, please call us at (805) 981-5060.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Documented yearly for ages 3-17

Height, weight, BMI percentile (use Z68.51-Z68.54) and nutrition (97802, 97803, 97804) and physical activity counseling (Z02.5, Z71.82)

Lead Screening in Children

Children **must** have one or more capillary or venous lead blood tests for lead poisoning by their second birthday.

Well Child Visits in the First 30 Months of Life

Well-Child Visits in the First 15 Months – 6 or more well child visits with a PCP

Well-Child Visits for Age 15 Months to 30 Months – 2 or more well child visits with a PCP

Child and Adolescent Well-Care Visits

Children and Adolescents ages 3-21 must have at least one comprehensive well-care visit with PCP or an OB-GYN annually

Childhood Immunizations

Code for all immunizations given and input previous immunizations into the chart or EHR as well as CAIR. Document if 2 or 3 dose Rotavirus given. *(Remember: IZs must be given prior to the 2nd birthday except for LAIV (influenza) which must be given on the child's second birthday)*

4 DTaP (90700)	3 HiB (90648)	4 Pneumo (90670)	2 Rotavirus (90681 x 2)
3 IPV (90713)	3 Hep B (90744)	1 Hep A (90633)	3 Rotavirus (90680 x 3)
1 MMR (90707 or 90710)	1 VZV (90716 or 90710)	2 Influenza (90686, 90685) (one of the two can be a LAIV)	

For DTaP, IPV, Hep B combination vaccine use 90723

For DTaP, IPV, HiB combination vaccine use 90698.

DTaP, IPV, HiB, PCV and Rotavirus do not count if given prior to 42 days after birth.

MMR, VZV, Hep A- must be given on or between 1st and 2nd birthday.

Influenza - must be given after 6 months and before 2nd birthday.

Hep B- one can be newborn vax within the first 8 days of life.

Immunizations for Adolescents

Adolescents, by their thirteenth birthday, must have at least the following: 1 dose of meningococcal vaccine (90734, given between ages 11-13), 1 dose of Tdap (90715, given between ages 10-13) and 3 doses of HPV (90649, 90651, given between ages 9-13). (Must have all IZs before 13th birthday)

Flu Vaccinations

Yearly for everyone 6 months and older.

Colorectal Cancer Screening

Colonoscopy documented within the last 10 years (45378, 45380, 45385) or flex sig (45330, 45331) within the last 5 years or 10 years with FIT every year, CT colonography (74261, 74262, 74263) within the last 5 years, FIT-DNA (Cologuard) within the last 3 years (81528), yearly guaiac FOBT (gFOBT) (82270) or yearly Fecal Immunochemical Occult Blood Test (FIT or iFOBT) (82274) for patients age 45-75 To exclude patients with history of colon cancer, use code Z85.038 or more specific code such as C18.4 for malignant neoplasm of transverse colon or 44150 for total colectomy. *(If patients refuse colonoscopy, offer FOBT or FIT at the time of the visit)*

Glycemic Status Assessment for Patients with Diabetes (GSD) formerly called Hemoglobin A1c Control for Patients with Diabetes*

Glycemic status assessment (HbA1c or glucose management indicator [GMI]) <8.0% is considered controlled for diabetic patients (types 1 and 2) ages 18-75 yearly. VCHCP obtains data from Quest and Cerner which is used for the Diabetes Disease Management Program. Glycemic status assessment >9.0% is considered poor control. *NOTE: No result in the medical record is treated as numerator non-compliant for all patients with diabetes diagnosis.*

Blood Pressure Control for Patients with Diabetes*

Blood Pressure control <140/90 for diabetic patients (types 1 and 2) ages 18-75 yearly. For patients with BP >140/90, consider rechecking at the time of the visit.

Eye Exam for Patients with Diabetes*

Dilated eye exam or retinal screening (92250) (or negative retinal screen the year prior) for diabetic patients (types 1 and 2) ages 18-75 yearly. Negative retinal screening (can be performed by any provider type (PCP, optometrist, ophthalmologist).

Remember patients can receive retinopathy screening through an ophthalmology office or at the following clinics: Magnolia, Las Islas, Academic Family Medicine Center (AFMC), West Ventura, Conejo Valley, Moorpark, Fillmore, Santa Paula Medical Clinic and Sierra Vista

Kidney Health Evaluation for Patients with Diabetes*

Kidney Health Evaluation for diabetic patients (type 1 and type 2) ages 18-85 yearly. Kidney health evaluation is defined by an estimated glomerular filtration rate (eGFR) AND a urine albumin-creatinine ratio (uACR). Both an eGFR and a uACR must be done during the measurement year.

Statin Therapy for Patients with Diabetes*

Patients 40-75 years old with diabetes who do **NOT** have atherosclerotic cardiovascular disease should receive at least 1 statin medication of any intensity and remain on a statin medication of any intensity for at least 80% of the treatment period.

**To exclude patients with gestational diabetes, use code O24.419.*

Breast Cancer Screening

Document screening mammogram (77067, 77055) is done every 2 years in age group 40-74. To exclude patients with bilateral mastectomy, use code Z90.13. *(VCHCP patients will receive a postcard for screening if due and will not require a MD order if done at a contracted radiology facility)*

Cervical Cancer Screening

Document pap (88141) done every 3 years in age group 21-64 or every 5 years in age group 30-64 if HPV co-testing (87624) also done. Every 5 years in the age group 30-64 if high risk HPV testing was done. To exclude patients' s/p hysterectomy not requiring pap, use code Z90.710. *(Remember to do Chlamydia screening at time of pap in age group 16-24, see next)*

Chlamydia Screening in Women

Documented yearly in sexually active woman in age group 16-24.

(Remember that this is to be done even though patients may not come in for annual exams. Patients dispensed prescription contraceptives are included in this measure.)

Appropriate Testing for Pharyngitis

For ages 3 and older, diagnosed with pharyngitis and dispensed an antibiotic after receiving a group A strep test. If coding for acute pharyngitis J02.9, acute tonsillitis J03.90 or strep pharyngitis J02.0, order group A strep test and treat appropriately with judicious use of antibiotics. Use CPT 87880 for rapid stress test POC.

Appropriate Treatment for URI

For ages 3 months and older who were given a diagnosis of URI and **NOT** prescribed an antibiotic. When prescribing antibiotics, use code for presumed bacterial etiology. For example, ICD-10 codes: [A49.9]; Bacterial infection, unspecified [J15.9]; Unspecified bacterial pneumonia; [J20.2] Acute bronchitis due to streptococcus

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

For ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis should **NOT** be prescribed an antibiotic unless there is bacterial etiology.

Prenatal and Postpartum Care

Prenatal care visits should be during the first trimester of pregnancy. Postpartum care visits should be on or between 7 and 84 days after delivery. Use code Z39.2or Z01.419 for postpartum care visits.

Asthma Medication Ratio

Identify patients ages 5-64 who have persistent asthma and ensure that at least half of the medications dispensed to treat their asthma are controller medications throughout the treatment/measurement period. **Patient is considered to have persistent asthma if they have any of the following: At least 1 ER visit with a principal diagnosis of asthma; at least 1 acute inpatient encounter with a principal diagnosis of asthma; at least 1 inpatient discharge with a principal diagnosis of asthma on the discharge claim; at least 4 outpatient visits, observation visits, telephone visits or e-visits or virtual check-ins, on different dates of service, with any diagnosis of asthma and at least 2 asthma medication dispensing events for any controller or reliever medication; at least 4 asthma medication dispensing events for any controller or reliever medications.** Examples of persistent asthma codes include J45.30-32, J45.40-42, J45.50-52. Note: Providers are encouraged not to allow automatic refill of rescue inhalers unless associated with an office visit to evaluate controller medication status.

Medical Assistance with Smoking and Tobacco Use Cessation: 3 parts yearly

Use code Z72.0 to document smoking disorder. 1) Advise smokers and tobacco users to quit, 2) discuss cessation medications and, 3) cessation strategies. 99406, 99407, Z71.6 (NOTE: Ventura County Public Health has a 5 A's Training Program. For more information, email callitquits@ventura.org)

Use of Opioids at High Dosage

Patients ages 18 years or older should NOT receive prescription opioids at a high dosage (MME greater than or equal to 90) for 15 or more days. Exclusions: Cancer and Sickle Cell Disease. (VCMC providers: Run CURES report with each prescription and place in patient's chart under "CURES report" and utilize Opioid Treatment Agreement in Adhoc forms).

Use of Opioids from Multiple Prescribers and Multiple Pharmacies

Patients ages 18 years or older should **NOT** receive prescription opioids from 4 or more different prescribers or from 4 or more different pharmacies. (VCMC providers: Run CURES report with each prescription and place in patient's chart under "CURES report" and utilize Opioid Treatment Agreement in Adhoc forms)

Risk of Continued Opioid Use

Patients ages 18 years or older who have a new episode of opioid use are at risk for continued opioid use if they have at least 15 days of prescription opioids in a 30-day period or at least 31 days of prescription opioids in a 62-day period.

Controlling High Blood Pressure

Patients 18-85 years of age who had a diagnosis of hypertension (HTN) should have their BP adequately controlled. Adequate control is <140/90 mm Hg. Measure and record BP at each visit. If BP is high (>139/89), recheck at the end of the visit. (NOTE: Systolic BP of 140 and diastolic BP of 90 is a miss. Must be below 140/90.) (NOTE: Telephone visits, e-visits and virtual check-ins are appropriate settings for BP readings. Please record reading and/or submit CPT Category II code (3074F, 3075F, 3077F, 3078F, 3079F, 3080F)

Use of Imaging Studies for Low Back Pain

Patients 18-75 years of age with a primary diagnosis of low back pain should **NOT** have an imaging study within 28 days of the diagnosis unless clinically appropriate. Clinically appropriate criteria include diagnosis of cancer, recent trauma, IV drug abuse, HIV, spinal infection, major organ transplant, prolonged use of corticosteroids, or neurologic impairment. Please code accordingly.

Depression Screening and Follow-up on Positive Depression Screen

All patients 12 and older should be screened annually for depression with a standardized screening tool. If screened positive, a follow care must be received within 30 days of positive depression screen finding. (VCMC providers should use the PHQ2/9 in Adhoc forms)

Plan All-Cause Readmissions

Patients discharged from the hospital should be seen by their PCP within 30 days of discharge to prevent the patient from being readmitted.

Adult Immunization Status

- Influenza – for ages 19 years and older yearly vaccine
- Td/Tdap – for ages 19 years and older one (1) Td/Tdap vaccine within the last ten (10) years
- Zoster – for ages 50 years and older, anytime on or after the 50th birthday, one (1) herpes zoster live vaccine or two (2) herpes zoster recombinant vaccine at least 28 days apart
- Pneumococcal – for ages 66 years and older, anytime on or after the 19th birthday, one (1) adult pneumococcal vaccine

Documenting Substance Use Disorder (SUD) Remission

Remission codes allow providers to capture the progress made by patients with SUDs. These codes indicate that a patient previously met criteria for a specific SUD but no longer exhibits the symptoms required for a current diagnosis. It acknowledges the positive changes in a patient's condition, indicating successful treatment and recovery.

Please refer to the following list of ICD-10 codes to document remission:

Please refer to the following list of ICD-10 codes to document remission		
Substance	Diagnosis	Description
Alcohol	F10.11	Alcohol Abuse, In Remission
	F10.21	Alcohol Dependence, In Remission
Opioids	F11.11	Opioid Abuse, In Remission
	F11.21	Alcohol Dependence, In Remission
Cannabis	F12.11	Cannabis Abuse, In Remission
	F12.21	Cannabis Dependence, In Remission
Sedative/Hypnotic/Anxiolytic	F13.11	Sedative/Hypnotic/Anxiolytic Abuse, In Remission
	F13.21	Sedative/Hypnotic/Anxiolytic Dependence, In Remission
Cocaine	F14.11	Cocaine Abuse, In Remission
	F14.21	Cocaine Dependence, In Remission
Other Stimulants/Amphetamine-type	F15.11	Other Stimulants/Amphetamine-type Abuse, In Remission
	F15.21	Other Stimulants/Amphetamine-type Dependence, In Remission
Hallucinogen/Phencyclidine	F16.11	Hallucinogen/Phencyclidine Abuse, In Remission
	F16.21	Hallucinogen/Phencyclidine Dependence, In Remission
Inhalants	F18.11	Inhalants Abuse, In Remission
	F18.21	Inhalants Dependence, In Remission
Other Psychotic Substances	F19.11	Other Psychotic Substances Abuse, In Remission
	F19.21	Other Psychotic Substances Dependence, In Remission

NOTE: When Using remission codes, other SUD diagnoses must be removed from the active diagnosis

Health Services Accomplishments for 2023-2024

and Case Management/Disease Management Program Effectiveness

Health Services Accomplishments

We are pleased to share our accomplishments for 2023-2024, which include the following highlights:

- Continued maintenance of the Healthx member and provider portals with regards to viewing the status of treatment authorization requests (TARs) and submission of TARs in the provider portal.
- Successful health coaching calls to members with diabetes and asthma under the Disease Management Program.
- Reduced the 45-day denial for lack of medical information due to implementation of process improvement in the Utilization Management (UM) department (Calling/communicating on all pended cases for clinical information & Medical Director's intervention by checking all pends and denials for appropriateness).
- Implemented several pharmacy programs in collaboration with Pharmacy Benefit Manager (Express Scripts) such as the National Preferred Formulary (NPF), Screen Rx Program to improve member medication adherence.
- Continued the Life Scan diabetes remote monitoring.
- Implementation of the Omada Prevention, Omada Hypertension and Propeller Asthma programs.
- Health Effectiveness Data Information Set (HEDIS) monitoring of scores and quality activities/interventions to improve preventive services.

We believe that these positive outcomes are a result of the efforts of our case managers to work with members in coordinating their care to improve their health and preventing inpatient readmissions and ER visits. Thank you for your continued support. We remain committed to providing high-quality care and service to our members and will continue to strive towards excellence in the coming year.

VCHCP 2024 AFFIRMATIVE STATEMENT REGARDING

Utilization Related to Incentive*

- 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.

Effectiveness of Disease Management Program

- Increase in the number of members with Hgb A1c <8 from 52.77% in 2022 to 57.85% in 2023 through the consistent efforts from the Diabetes Disease Management care coordinators/case managers.
- A higher percentage of members, 58.33% of the enrolled members in the CM program, had A1c testing done within 6 months following health coaching calls.
- Increased success rate of health coaching calls to 44.66% for 2023, from 36.95% in 2022, an increase of 7.71 percentile points. The percentage of members with high HgbA1c has shown significant decrease, after health coaching (from 52.7% to 24.3%).

Effectiveness of Case Management Program

- Overall member satisfaction with complex case management was 100%, with episodic/short case management was 98.4%.
- Significant decrease in the number of members requiring inpatient admission after complex case management enrollment at 71.42% (was 50% decrease in 2022). There was a 45.45% reduction in the number of members who required ER visits after complex case management for this year which is also an improvement from 2022 which was 40%.

HEDIS

TIPS & INFORMATION

Improving Quality of Care

HEDIS RATES ARE SCORED BASED ON ADMINISTRATIVE BILLING DATA.
USE THE BELOW TIPS TO HELP IMPROVE YOUR HEDIS PERFORMANCE SCORES:

- Ensure patients are accurately diagnosed and services are rendered appropriately based on medical necessity and clinical practice guidelines.
- Follow the American Academy of Pediatrics/ Bright Futures Periodicity Schedule and U.S. Preventive Services Task Force preventive and clinical practice guidelines for rendering health services to patients during wellness visits.
- Schedule appointments and review patient charts prior to patient visits to close care gaps.
- Ensure patients are accurately diagnosed with persistent asthma.
- Ensure that asthma medication, especially controller medication, is being dispensed to the patient in accordance with the proper medication schedule or need.
- Document date of mammogram along with proof of completion and develop standing orders along with automated referrals (if applicable) for patients ages 50–74, who need screening.
- The percentage of women 21-64 years of age who were screened for cervical cancer:
 - o For women ages 21–64 who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years.
 - o For women ages 30–64 who were recommended for routine cervical cancer screening and had a cervical high-risk human papillomavirus (hrHPV) testing within the last 5 years.
 - o For ages 30–64 who were recommended for routine cervical cancer screening and had a cervical cytology/cervical high-risk human papillomavirus co-testing within the last 5 years.
- Order a chlamydia screening and provide follow-up for patients who are pregnant, taking contraceptives or identified themselves as sexually active.
- Instruct staff to take a repeat reading if abnormal BP is obtained.
- Schedule appointments and complete services for patients ages 18–75 with diagnosis of diabetes on an annual basis to assist with health maintenance of the disease processes. The following services are required:
 - o Order at least one HbA1c screening annually. Repeat test if A1c is greater than 7.9%.
 - o Collect A1c data completed during inpatient visits or elsewhere in order to evaluate if a repeat test is required.
- Schedule patient's postpartum care visit with an OB/GYN practitioner, midwife, family practitioner, or other PCP on or between 7–84 days after delivery.
- Ensure accurate action, follow-up, documentation, and billing of services.
- Submit claims correctly and in a timely manner.
- Correct encounters/claims with erroneous diagnoses.

We need to work together to improve and maintain higher quality of care. When our members are healthy, everyone benefits! The reminders above only provide a snapshot of some of the HEDIS measures. Please refer to the HEDIS Cheat Sheet you will receive in the mail. If you need additional information or assistance related to HEDIS, please call our HEDIS Program Administrator at **(805) 981-5060**.

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 Prior Authorization (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

You, your designee, or your prescribing doctor 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 exception via online request available in the VCHCP member website vhealthcareplan.org/members/requestPharmacyExceptionForm.aspx or by calling the Plan at (805) 981-5050.
- Ask the Plan to make an 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 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 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 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.
- Exception 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 exception request for step therapy/nonformulary/ prior authorization drug did not meet any of the enumerated criteria in section 1367.206(b).
- The 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 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 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 to reverse a denial of a prior authorization, formulary exception, or step therapy request applies to the duration of the prescription including refills.

NEGATIVE FORMULARY UPDATE

To ensure that prescribing practitioners are notified of "negative" formulary updates, a list of affected members is sent to VCHCP medical management staff by Express Scripts. The list of affected members has information on prescribing practitioners' name and contact information, excluded medications and preferred medication alternatives. The VCHCP Medical Management staff notifies prescribing practitioners by phone or fax or CERNER messaging of the change to the formulary and offers the preferred medication alternatives.

If a prescribing practitioner indicates medical necessity for the member to continue the excluded/non-formulary medication, the practitioner is informed that the request would be handled through the Plan's formulary exception request authorization process.

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

PHARMACY UPDATES & DELETIONS

Ventura County Health Care Plan updates the formulary with changes on a monthly basis and gets re-posted monthly on the VCHCP's member and provider website. Here is the direct link of the electronic version of the formulary posted on the Ventura County Health Care Plan's website vhealthcareplan.org/members/programs/docs/ProviderDrugList.pdf.

The Ventura County Health Care Plan's Pharmacy & Therapeutics Committee has recently approved a list of additions and deletions to the formulary. The list can also be accessed here:

[ProviderNotificationAddsAndDeletes.pdf](https://vhealthcareplan.org/members/programs/docs/ProviderNotificationAddsAndDeletes.pdf) (vhealthcareplan.org)

Additional information regarding the National Preferred Formulary is available through Express Scripts (ESI). Logging in is required.

Note: The Plan's Drug Policies, updated Step Therapy and Drug Quantity Limits can also be accessed at: vhealthcareplan.org/providers/providerIndex.aspx.

- Plan's Drug Policies vhealthcareplan.org/providers/priorAuthDrugGuidelines.aspx
- Step Therapy vhealthcareplan.org/providers/docs/padg/steptherapy/StepTherapyCheatSheet.pdf
- Drug Quantity Limit
 - o vhealthcareplan.org/members/programs/docs/DQMAAdvantage.pdf
 - o vhealthcareplan.org/members/programs/docs/DQMAAdvantagePlus.pdf
 - o vhealthcareplan.org/members/programs/docs/DQMLimited.pdf
- Preferred Medications list vhealthcareplan.org/members/programs/docs/ProviderDrugList.pdf

A member or a member's designee 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 submitting an exception via online request available in the VCHCP member website (vhealthcareplan.org/members/requestPharmacyExceptionForm.aspx) or by calling the Plan at (805) 981-5060. For more information about the Step Therapy, the policy can be found at the Plan's website vhealthcareplan.org/providers/docs/padg/steptherapy/StepTherapyCheatSheet.pdf.

To access the policy and procedure for the Drug benefit Program of VCHCP, please click this link vhealthcareplan.org/members/programs/docs/PrescriptionMedicationBenefitProgramDescription.pdf.

2024 National Preferred Formulary Exclusions

Excluded medications are not covered by the National Preferred Formulary beginning January 1, 2024, unless otherwise noted. Please note that members filling prescriptions for one of these excluded drugs may pay the full retail price. Please discuss the alternative preferred medications with your patients and provide a new prescription for one that you feel is right for the patient.

To access the list of National Preferred Formulary Exclusions, please visit our website at vhealthcareplan.org/members/programs/docs/NationalPreferredFormularyExclusions.pdf.

Formulary Web Posting

Ventura County Health Care Plan updates the formulary with changes on a monthly basis and re-posted monthly in VCHCP's member and provider website. The formulary includes information on covered pharmaceuticals and pharmaceutical management procedures including co-payments, prior authorization, drug limits, generic substitution, therapeutic interchange, and step-therapy.

Please refer to the Formulary Drug List posted in the VCHCP provider website by clicking this link: vhealthcareplan.org/members/programs/docs/ProviderDrugList.pdf

ATTENTION:
VCHCP PCP Primary Care Practitioners!

The following is important information regarding
appropriate Antidepressant Medication Management
INFORMATION FOR PRESCRIBERS: Depression

Screening & Diagnosis	Treating Patients Who Have Depression Disorder
Depression screening is recommended in preventive care assessments. Simple screening questions may be performed as well as using more complex instruments. Any positive screening test result should trigger a full diagnostic interview using standard diagnostic criteria. Resources include the Patient Health Questionnaire (PHQ) and GAD-7 which offers clinicians concise, self-administered screening and diagnostic tools for mental health disorders, which have been field-tested in office practice. The screeners are quick and user friendly, improving the recognition rate of depression and anxiety and facilitating diagnosis and treatment. Be sure to include appropriate lab tests with a comprehensive medical exam which may identify metabolic underlying causes for the depression • persons with other psychiatric disorders • substance misuse • persons with a family history of depression • persons with chronic medical Diseases	If you have determined that your patient has depression, the best practice for treating depression includes a treatment plan involving: • Referral to Psychotherapy (such as individual, family, group, cognitive behavioral) AND • Medication for patients who score moderate to severe depression on a screening tool Our accepted clinical best practice guideline for Major Depression is the American Psychiatric Association Practice Guideline: Treatment of Patients with Major Depressive Disorder. This guideline notes that the treating clinician needs to keep in mind suicide assessment, psychotherapy, support, and medication monitoring. Other depressive or mood disorders benefit from this approach. The National Committee for Quality Assurance (NCQA) publishes health plan HEDIS (Health Effectiveness Data Information Set) rates for adult patients who are diagnosed with Major Depression and are started on an antidepressant medication. To meet the guidelines patientsb must remain on an antidepressant drug for at least 180 days (6 months). To help with compliance, VCHCP suggests that you discuss with patients the length of time it may take before they see the full effect of a medication. • Specifically, it may take 10 to12 weeks to experience the full effect of a medication. • Medication adherence is indicated for at least six (6) months as the risk of relapse is greatest during this time period. • The World Health Organization recommends continuing treatment for 9-12 months. • The Journal of Clinical Psychiatry recommends continuing treatment for 4-6 months after a response. • The American Psychiatric Association Best Practice Guidelines recommends continuing treatment at the same dose, intensity, and frequency for 4-9 months after full remission.

Treating Patients Who Have Depression or Bipolar Disorder

The best practice for the treatment of depression and bipolar disorder includes a treatment plan involving:

- Medication
- Therapy
- Self-empowerment/recovery tools

When working with a patient, it is important to communicate with all members of the treatment team about the treatment provided, the patient's status, and any potentially complicated factors. You should also reinforce with your patients that mental health issues can be successfully treated by adhering to their treatment plan.

The Following Resources May Be Helpful To You and Your Patients

- [nami.org](https://www.nami.org) - National Alliance on Mental Illness
- [psychiatryonline.org/mdd](https://www.psychiatryonline.org/mdd) - American Psychiatric Association Major Depression Best Practice Guideline
- public.providerexpress.com/content/opec-provexpr/us/en.html

Optum Provider Express

Optum's practitioner website refers to the American Psychiatric Association (APA) Guidelines for recognizing and treating Major Depressive Disorder; patient education materials are also available.

Optum's practitioner website includes a "Behavioral Health Toolkit for Medical Providers" which includes screening tools for depression as well as other behavioral health issues. Also found at this link public.providerexpress.com/content/opec-provexpr/us/en/clinical-resources/PCP-Tool-Kit/Behavioral-Health-Toolkit--Medical-Providers.html

Optum's Medical Director
Phone Line
(415) 547-5013

AUTISM SPECTRUM DISORDER:

VENTURA COUNTY HEALTH CARE PLAN'S AUTISM CASE MANAGEMENT PROGRAM

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder that affects communication, behavior, and social interaction. According to the CDC's Autism and Developmental Disabilities Monitoring (ADDM) Network, about 1 in 44 8-year-old children have been identified with ASD.

At Ventura County Health Care Plan, we recognize the importance of providing support to individuals and families affected by ASD. That's why we offer our Autism Case Management Program for all members identified with Autism. This program is designed to provide personalized support and resources to our members with ASD.

We understand that managing the care of individuals with ASD can be complex and challenging. Our Autism Case Management Program is staffed with care managers who have specialized training and experience in working with individuals with ASD. Our care managers work closely

with our members, their families, and their providers to develop individualized care plans that address the unique needs of each member.

We encourage all health plan providers to refer their members identified with Autism to our Autism Case Management Program. If you haven't already done so, please refer all members identified with Autism, including members new to your practice, to our program.

Referring members to our Autism Case Management Program is easy. You can refer members online at vchealthcareplan.org/members/requestAssistanceForm.aspx, or by calling (805) 981-5060.

We believe that by working together, we can provide the best possible care and support for our members with ASD. Thank you for your partnership and for your commitment to improving the lives of our members.

VCHCP RESOURCES *for* Member Behavioral Health and Substance Abuse

Member Website and Provider Directory
[LiveandWorkWell.com](https://liveandworkwell.com)

Optum Intake and Care Management For Intake and Referrals (800) 851-7407

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

A 24/7 helpline for VCHCP Providers and Patients

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

If you have paid for these services out of pocket, you can submit claims for retrospective review to the following address:

Optum Claims Processing
P.O. Box 30755
Salt Lake City, UT 84130-0755

Accessing Services *for* Behavioral Health



Contact OptumHealth Behavioral Solutions of California “Life Strategies” Program at **(800) 851-7407** or visit

the website at [Liveandworkwell.com/content/en/public.html](https://liveandworkwell.com/content/en/public.html).

Further information may also be obtained by consulting your Ventura County Health Care Plan Commercial Members Combined Evidence of Coverage (EOC) Booklet and Disclosure Form.

Contact VCHCP Member Services at **(805) 981-5050** to request an EOC copy or go to the Plan’s website at vchealthcareplan.org/members/programs/docs/countyemployees/EOCCountyAndClinicEmp2023.pdf.

Information on authorization of Plan Mental Health and Substance abuse benefits is available by calling the Plan’s Behavioral Health Administrator (BHA) at **(800) 851-7407**. A Care Advocate is available twenty-four (24) hours a day, seven (7) days a week to assist you in accessing your behavioral healthcare needs. For non-emergency requests, either you or your Primary Care Provider may contact Life Strategies for the required authorization of benefits prior to seeking mental health and substance abuse care.

Optum Case Management Referral for Members with Social Determinants of Health

Providers can help members with complex behavioral health conditions secure needed services and resources via the Optum Case Management Program. Providers may refer members who require assistance with social determinants of health (such as education/support regarding illness, coordination with support system, transportation and food security) to Optum Case Management. Please contact Optum Case Management at care.coordination@optum.com to make the referral.



Treatment for individuals with substance use disorder

How you can help

- Encourage your patient to schedule routine follow-up visits.
- Reach out if they do not attend their appointment.
- Obtain release of information (ROI) to include the patient’s family, support system and other providers.
- Assess and work with the patient’s existing motivation to change, and address co-occurring medical-behavioral conditions.

Treating co-occurring disorders

- Discuss with your patient how continued treatment helps prevent relapse.
- Refer for medications for opioid use disorder (MOUD) or medications for alcohol use disorder (MAUD).
- For patients with an active primary or secondary diagnosis of moderate to severe substance use disorder (SUD), Optum recommends professional services in combination with community-based recovery support services.



Treatment timeline

When newly diagnosing individuals with a SUD, please schedule follow-up treatment within 14 days of the diagnosis and 2 or more additional services within 34 days of the initial visit.

Optum



Treatment support for opioid use disorders



Medications for opioid use disorder (MOUD) help control withdrawal symptoms and cravings and help maintain long-term stability.

About MOUD and MAUD

MOUD is the standard of care for OUD and supports recovery. It pairs FDA-approved medication with support services to treat substance use disorders and prevent opioid overdose.

There are many forms of MOUD which can be used to treat MOUD, such as agonist and antagonist therapies, which may be provided in a variety of treatment settings, including virtually.

Discontinuation of MOUD may result in relapse, overdose and death. Individuals engaged in MOUD and psychosocial supports have better outcomes than medication alone.

Pharmacotherapy for opioid use disorder

The Pharmacotherapy for Opioid Use Disorder (POD) HEDIS® measure assesses members ages 16 and older with an OUD with a new OUD pharmacotherapy event and on the medication for at least 180 days.



With MOUD, the relapse rate for those with OUD decreases to

50% at one year.



Follow-up care after discharge

Help patients get care within 7 days after discharge

If any of your patients have recently been discharged from an emergency department or an inpatient hospital stay with a mental health (MH) or substance use disorder (SUD) diagnosis, you play an important role in ensuring that they receive appropriate follow-up care after discharge.*



Helpful tools and resources

These resources can assist you and your patients with follow-up care after discharge:

[providerexpress.com](https://www.providerexpress.com)
Access resources for your patients on mental health, substance use and crisis support like educational materials, screening tools and assessments.

.....
[Recovery and Resiliency Toolkit](#)
Determine personal strengths and facilitate recovery and wellness planning.

.....
[Medication for opioid or alcohol use disorder \(MOUD or MAUD\)](#)
Learn more about MOUD and MAUD.

.....
[liveandworkwell.com](https://www.liveandworkwell.com)
Access patient education materials and mental health and substance abuse provider information, use guest access code “clinician.”

* National Committee for Quality Assurance 2022 HEDIS Specifications. See [NQF-Endorsed Measures at ncqa.org](#).

Tips for success

- Discuss the importance of attending appointments with patients and suggest they set up a reminder in their phone/calendar.
- Send reminders to patients/caregivers ahead of the appointment.
- Ask patient, “Is there is a support person you would like to have at the first appointment with you?”
- Ask patient, “Do you have transportation or other reasons that would keep you from attending your appointment?”
- Suggest a virtual appointment, if applicable.
- Outreach to reschedule and discuss the need for additional support for patients who cancel or miss an appointment.

Virtual visits are an effective way to provide care within 7 days after discharge.

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Nothing herein is intended to modify the Provider Agreement or otherwise dictate MH/SA services provided by a provider or otherwise diminish a provider’s obligation to provide services to members in accordance with the applicable standard of care. This information is provided by Optum Quality Management Department. If you would like to be removed from this distribution or if you have any questions or feedback, please contact us at email: qmi_emailblast_mail@optum.com. Please include the email address you would like to have removed when contacting us.

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BH00224-24-FLY



Antidepressant Medication Screening & Management

We appreciate you taking an active role in screening your patients for depression



The American Psychiatric Association recommends patients complete the Patient Health Questionnaire (PHQ-9) screening tool

Use a screening tool

- The PHQ-9 can aid in identifying the severity of depressive symptoms, especially before prescribing medication
- The PHQ-9 instruction manual recommends consideration of medication only for those patients who score in the moderate to severe range (scores above 15)

See page 2 for a PHQ-9 scoring guide

Resources

- More tools and information about behavioral health issues are available on [providerexpress.com](#) > Clinical Resources > Behavioral Health Toolkit for Medical Providers
- Patient education information is available on [liveandworkwell.com](#) > use access code "clinician"

Refer to a Mental Health Professional

You can request coordination of care and referrals for patients by calling the number on the back of the patient's health plan ID card or searching [liveandworkwell.com](#) > use access code "clinician"

Prior to prescribing an antidepressant for patients assessed to have Mild to Moderate Depression:

- Refer to supportive counseling as first treatment recommendation
- Encourage the use of self-help apps for depression. Apps are useful for symptom tracking, sleep and meditation, self-guided therapy, or other supports.

For patients assessed to have Moderate to Severe Depression:

- Consider prescribing an antidepressant
- Encourage follow-up visits to discuss medication side effects, response to treatment, and adherence. Consider telephonic check in with patients between in person visits.
- Review tips to increase medication adherence with patients. Help patients move past stigma and see treatment for mental health and physical health equally.
- Discuss barriers and identify solutions at the time of the prescription
- Encourage use of mail-order prescription fill. Remind your patients to sign up for refill reminders through their pharmacy, or utilize self-help apps for pill and refill reminders

Sources: Kroenke, K., Spitzer, R.L., & Williams, J.B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*. 16(9):606-13. doi: 10.1046/j.1525-1497.2001.016009606.x.
American Psychiatric Association (2022). <https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures>

High-Level Stratification and Interventions for Depression

PHQ-9
Score: 5-9
Mild

WATCHFUL
WAITING

Repeat PHQ-9
Assessment at
follow-up visit

Encourage use of
self-help apps for
depression

Assess for
differential
diagnosis

[Click here to
access the
member website
to search for
behavioral health
providers \(Use
access code
"Clinician"\)](#)

PHQ-9
Score: 10-14
Moderate

MONITOR

Repeat PHQ-9
Assessment at
follow-up visit

Refer to
behavioral health
therapy and
Optum Case
Management for
additional support

Provide
educational
information
around
depression

Provide
community
resource referrals
as needed

PHQ-9
Score: 15-19
Moderately
Severe

ACTIVE
TREATMENT

Repeat PHQ-9
Assessment at
least monthly

Assess for
pharmacotherapy

Refer to
behavioral health
therapy and
Optum Case
Management for
additional support

Coordinate with
behavioral health
treatment provider

Work with patient
on using self-
management tools

Provide
community
resource referrals
as needed

PHQ-9
Score: 20-27
Severe

IMMEDIATE
TREATMENT

Repeat PHQ-9
Assessment at
least monthly

Initiate
pharmacotherapy

Expedite a referral
to behavioral
health for
individual, family
or group therapy

Coordinate with
behavioral health
treatment provider

Monitor for
medication
adherence*

Provide
community
resource referrals
as needed

Effectively coordinating care between treatment professionals can lead to improved health outcomes. Please be sure to have the member sign a release of information form.

You may use your own form or [click here](#) to access the Optum Confidential Exchange of Information form.

It is recommended that patients remain on antidepressant medication for at least 180 days (6 months) National Committee for Quality Assurance 2023 HEDIS Specifications see NQF-Endorsed Measures at [www.ncqa.org](#)



Important Information about Coordination of Care (COC)

Optum requires contracted behavioral health practitioners and providers to communicate relevant treatment information and coordinate treatment with other behavioral health practitioners and providers, primary care physicians (PCPs), and other appropriate medical practitioners involved in a member's care.

WHY?

COC between behavioral health and medical practitioners benefits your practice because it:

- Establishes collaborative, credible relationships
- Provides opportunities for referrals

COC improves members' quality of care by:

- Avoiding potential adverse medication interactions
- Providing better management of treatment and follow-up for members

Resources for Coordinating Care

Our practitioner website, providerexpress.com, includes tools and resources to support you in coordinating care. Select the "Clinical Resources" tab at the top of the main page, then select "Coordination of Care."

To gain consent to share relevant treatment information with other treating practitioners, you may use the Optum "[Confidential Exchange of Information Form](#)." This consent form is completed by you and then signed by your member.

Use the "[Coordination of Care Checklist](#)" to document your efforts to coordinate care with your members' other practitioners, including when your members decline further care.

WHEN?

COC may be most effective:

- After the initial assessment
- At the start or change of medication
- Upon discharge
- Upon transfer to another provider or level of care
- When significant changes occur, such as (diagnosis, symptoms, compliance with treatment)

Guidelines to Facilitate Effective Communication

When scheduling appointments for new members, request they bring names and contact information (address, phone number, etc.) for their other treating practitioners.

Complete a COC form with the member within a **week** of your initial assessment and **annually** thereafter. Provide other treating practitioners with the following information:

- A brief summary of the member's assessment and treatment plan recommendations
- Diagnoses (medical and behavioral)
- Medications prescribed (brand or generic name, strength and dosage)
- Your contact information (name, telephone, email, fax number, and the best time you may be reached by phone, if needed)

Nothing herein is intended to modify the Provider Agreement or otherwise dictate MH/SA services provided by a provider or otherwise diminish a provider's obligation to provide services to members in accordance with the applicable standard of care. This information is provided by the Optum Quality Management Department. If you would like to be removed from this distribution or if you have any questions or feedback, contact us at email: gmi_emailblast_mail@optum.com. Please include the email address you would like to have removed when contacting us.

STANDARDS FOR

MEMBERS' RIGHTS & RESPONSIBILITIES

Ventura County Health Care Plan (VCHCP) 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.

For information regarding the Plan's privacy practices, please see the "HIPAA Letter and Notice of Privacy Practices" available on our website at: vchealthcareplan.org/members/memberIndex.aspx.

Or you may call the Member Services Department at (805) 981-5050 or toll free at (800) 600-8247 to have a printed copy of this notice mailed to you.

NEW TO THE NETWORK

Abigail Nimz, M.D., an OB/GYN at Mandalay Bay Women & Children's Medical Group (VCMC) in Oxnard and Sierra Vista Family Medical Clinic (VCMC) in Simi Valley, has been added February 2024.

Adam Shellito, M.D., a General Surgeon at Anacapa Surgical Associates (VCMC) in Ventura, has been added effective October 2023.

Alejandro Tinsly, F.N.P., a Nurse Practitioner at Clinicas Del Camino Real Inc., in Oxnard, has been added effective March 2024.

Anastasia Warde, M.D., an OB/GYN at Sierra Vista Family Medical Clinic (VCMC) in Simi Valley, has been added effective October 2023.

Ashley Netrow, F.N.P., a Nurse Practitioner at Clinicas Del Camino Real Inc., Ojai Valley Community Health Center in Ojai, has been added effective February 2024.

Casey Whipple, M.D., a Family Medicine physician at Magnolia West (VCMC) in Oxnard, has been added effective December 2023.

Christine Weber, P.A.-C., a Physician Assistant at Main Street Obstetrics & Gynecology in Ventura, has been added effective January 2024.

Christopher Dru, M.D., a Urologist at Anacapa Urology Clinic (VCMC) in Ventura, has been added effective January 2024.

Dhruv Verma, M.D., a Gastroenterologist at Medicine Specialty Center West (VCMC) in Ventura, has been added effective August 2023.

Hailey Eisner, D.O., a Female Pelvic and Reconstructive surgeon at Anacapa Urology (VCMC) in Ventura, has been added effective August 2023.

Irish Dawn Dorsey, P.A.-C., a Physician Assistant at Matthew L. Bloom, D.O., PC, in Ventura, has been added effective March 2024.

Jacqueline Shellito, M.D., an OB/GYN at Sierra Vista Family Medical Clinic (VCMC) in Simi Valley, has been added effective December 2023.

James Caines, D.O., a Family Medicine physician at Clinicas Del Camino Real Inc., Roberto S. Juarez Health Center in Oxnard, has been added effective January 2024.

Jennifer Steen, M.D., an OB/GYN at Main Street Obstetrics & Gynecology in Ventura,

has been added effective November 2023.

Jessica Perez, P.A.-C., a Physician Assistant at Clinicas Del Camino Real Inc., Karen R. Burnham Health Center in Oxnard, has been added effective March 2024.

Jonathan Casillas, P.A.-C., a Physician Assistant at Clinicas Del Camino Real Inc., in Simi Valley, has been added effective November 2023.

Justin Mikesell, P.A.-C., a Physician Assistant at Pacifica Center For Dermatology in Camarillo, has been added effective April 2024.

Kaitlyn Phelps, P.A.-C., a Physician Assistant at California Dermatology Institute in Thousand Oaks, has been added effective October 2023.

Kenisha Thomas, F.N.P., a Nurse Practitioner at Clinicas Del Camino Real Inc., La Colonia in Oxnard, has been added effective January 2024.

Krystine Jimenez Eusebio, P.A.-C., a Physician Assistant at Clinicas Del Camino Real Inc., Roberto S. Juarez Health Center in Oxnard, has been added effective January 2024.

Linnea Rietkerk, R.D.N., a Registered Dietician Nutritionist at 360 Nutrition Consulting in Camarillo, has been added effective January 2024.

Logan Horejsi, P.A.-C., a Physician Assistant at California Dermatology Institute in Ventura, has been added effective October 2023.

Manja Perilla, F.N.P., a Nurse Practitioner at Magnolia Family Medical Center (VCMC) in Oxnard, has been added effective February 2024.

Meaghan Pinheiro, M.D., an OB/GYN at Main Street Obstetrics & Gynecology in Ventura, has been added effective November 2023.

Mina Ananth, M.D., a Family Medicine physician at Santa Paula Medical Clinic (VCMC), has been added effective November 2023.

Mohammad Khan, M.D., a Gastroenterologist at Genesis Healthcare Partners in Camarillo and Oxnard, has been added effective October 2023.

Nicole Abell, D.O., an OB/GYN at Main Street Obstetrics & Gynecology in Ventura, has been added effective November 2023.

Nikkee Amin, M.D., a Child Neurologist at Sierra Vista Family Medical Clinic (VCMC) in Simi Valley, has been added effective November 2023.

Olivia Granger, P.A.-C., a Physician Assistant

at Clinicas Del Camino Real Inc., Karen R. Burnham Health Center in Oxnard, has been added effective November 2023.

Olivia Low, M.D., a Pediatrician at Clinicas Del Camino Real Inc., Karen R. Burnham Health Center in Oxnard, has been added effective January 2024.

Paramjit Singh, D.O., a Rheumatologist at Conejo Valley Family Medical Group (VCMC) in Thousand Oaks and Magnolia Family Medical Center (VCMC) in Oxnard, has been added effective January 2024.

Patti Wicklund, F.N.P., a Nurse Practitioner at Ojai Valley Family Medicine Group in Ojai, has been added effective January 2024.

Rebecca Richmond, F.N.P., a Nurse Practitioner at Alta California Medical Group in Simi Valley, has been added effective January 2024.

Rukmini Enjamuri, M.D., a Gastroenterologist at Genesis Healthcare Partners in Camarillo and Oxnard, has been added effective February 2024.

Sahil Vohra, D.O., an Orthopedic Surgeon at West Ventura Orthopedics and Podiatry Clinic (VCMC) in Ventura, has been added effective December 2023.

Sherri Tysch, D.O., a Pediatrician at Community Pediatrics Medical Group in Moorpark and Westlake Village, has been added effective November 2023.

Stephanie Pyatkovskiy, N.P., a Nurse Practitioner at Moorpark Family Care Center (VCMC) in Moorpark, has been added effective October 2023.

Sterling Adams, D.O., a Family Medicine physician at Clinicas Del Camino Real Inc., Ojai Valley Community Health Center, has been added effective November 2023.

Sydney Tang, P.A.-C., a Physician Assistant at California Dermatology Institute in Thousand Oaks, has been added effective October 2023.

Tessa Tejero-Bingham, P.A.-C., a Physician Assistant at Ventura Orthopedics Medical Group in Camarillo, Simi Valley, and Thousand Oaks, has been added effective January 2024.

Victoria Moor, F.N.P., a Nurse Practitioner at Clinicas Del Camino Real Inc., Roberto S. Juarez Health Center in Oxnard, has been added effective November 2023.

LEAVING THE NETWORK

Dipti Sagar, M.D., a Gastroenterologist at Magnolia Family Medical Center (VCMC) in Oxnard and Medicine Specialty Center West (VCMC) in Ventura, has left effective December 2023.

Emily Ewing, F.N.P., a Nurse Practitioner at Clinicas Del Camino Real Inc., La Colonia in Oxnard, has left effective February 2024.

Ira Silverman, M.D., an OB/GYN at Academic Family Medical Center (VCMC) in Ventura and Mandalay Bay Women & Children's Medical Group (VCMC) in Oxnard, has left effective January 2024.

Jodi Watson, C.N.M., a Certified Nurse Midwife at Santa Paula Hospital Clinic (VCMC) and West Ventura Medical Clinic (VCMC) in Ventura, has left effective December 2023.

John Huebner, P.A.-C., a Physician Assistant at Dignity Health Medical Group Ventura County in Oxnard, has left effective October 2023.

Kristen Motley, P.A.-C., a Physician Assistant at Clinicas Del Camino Real Inc., in Moorpark, has left effective December 2023.

Larissa Larsen, M.D., a Dermatologist at Medicine Specialty Center West (VCMC) in Ventura, has left effective December 2023.

Manvir Sohal, M.D., a Family Medicine physician at Clinicas Del Camino Real Inc., in Simi Valley, has left effective June 2023.

Martin Weiss, M.D., a Rheumatologist at Conejo Valley Family Medical Group (VCMC) in Thousand Oaks and Magnolia Family Medical Center (VCMC) in Oxnard, has left effective December 2023.

Misty Eleryan, M.D., a Dermatologist at Pacifica Center For Dermatology in Camarillo, has left effective October 2023.

Nicholas Campbell, P.A.-C., a Physician Assistant at Ventura Orthopedic Medical Group in Oxnard, has left effective June 2023.

Nima Nassiri, M.D., a Urologist at Anacapa Urology Clinic (VCMC) in Ventura, has left effective September 2023.

Paul Silverman, M.D., a Urologist at Anacapa Urology Clinic (VCMC) in Ventura, has left effective December 2023.

Peter Soliman, M.D., a Family Medicine physician at Clinicas Del Camino Real Inc., in Moorpark, has left effective August 2023.

Rosalva Romero, F.N.P., a Nurse Practitioner at Rose Avenue Family Medical Group in Oxnard, has left effective December 2023.

Soraida Rodriguez, N.P., a Nurse Practitioner at Anacapa Neurosurgery (VCMC) in Ventura, has left effective September 2023.

Wallace Baker, M.D., a Family Medicine physician at Academic Family Medicine Center (VCMC) in Ventura, has left effective March 2024.

CHANGES

Alta California Medical Group in Simi Valley has moved to a new location in Simi Valley, effective November 2023.

Cardiology Associates Medical Group in Ventura has moved to a new location in Ventura, effective January 2024.

Central Coast Center for Gynecologic Oncology has changed their name to Community Memorial Gynecologic Oncology, effective March 2024.

CMH Centers for Family Health in Camarillo, Oxnard and Santa Paula has changed their name to Community Memorial Health Center, effective March 2024.

Coastal Allergy Care in Simi Valley has permanently closed their doors, effective November 2023.

Dignity Health Medical Group Ventura County in Oxnard has moved suite numbers, effective January 2024.

Los Robles Homecare Services, a Home Health Agency, in Thousand Oaks has moved to a new location in Thousand Oaks, effective February 2024.

Magnolia Family Medicine Center West (VCMC) has updated their name to Magnolia West (VCMC), effective January 2024.

Mission Hospice of Ventura has moved to a new location in Oxnard, effective February 2024.

San Buenaventura Urology has changed their name to Community Memorial Urology, effective March 2024.

Solar Urgent Care in Ventura has permanently closed their doors, effective September 2023.

Vista Del Mar Medical Group in Camarillo has moved to a new location in Camarillo, effective March 2024.

PROVIDER SATISFACTION

Survey

THE PROVIDER SATISFACTION SURVEY,

Currently Underway



administered by Press Ganey, is designed to measure your satisfaction with the Ventura County Health Care Plan (VCHCP), as well as your satisfaction with other plans you may participate in.

VCHCP values the opinion of our providers. Your continued participation and feedback helps us determine which areas of service have the greatest affect on the overall satisfaction with our plan. In addition, it helps us identify and target areas in need of improvement.

We will continue to evaluate this information on an annual basis, and improve your experience with the plan, as well as the quality of care provided to our members.

We encourage you to complete and return the survey ASAP and thank you for your time.