

FAQs

Quality

We will lose the protections of Kansas peer review law if we report member identifiable information to an outside managed care organization.

Answer: Contracts providers sign in order to be in the ValueOptions network require the reporting of critical incidents. In an effort to work with providers while still obtaining the data needed, ValueOptions will not require member specific information such as member name and number. We may need to conduct chart audits on records as part of the critical incident process. In these instances, providers will have the option of copying the complete record and removing member identifiable information prior to the review.

Are elopements for treatment under the critical incidents policy just for residential treatment?

Answer: This is any elopement from treatment where the person is considered to be a danger to themselves or others. It applies to level 3 or higher.

When are the Regional QI Meetings and how do I get an invitation?

Answer: Whenever possible, the Regional QI meetings will be held in the afternoon of the State AAPS provider meetings. Invitations to the meetings will be sent prior to the meeting. If you have not received an invitation and would like to be part of the meeting, please contact sheree.marzka@valueoptions.com

Why does ValueOptions need to know if there is a critical incident at my facility?

Answer: The contract signed by providers includes a section about reporting critical incidents. It is important that ValueOptions know about critical incidents that take place in order to monitor member safety.

Is there a website that references the federal regulations and requirements?

Answer: Yes. <http://www.gpoaccess.gov/cfr/index.html> Search by keyword PIHP.

Why can't ValueOptions send me member information via e-mail?

Answer: HIPAA prevents the communication of protected health information (PHI) via unencrypted e-mail. Please contact Michael.kadlicek@valueoptions.com if you would like to be set up with a Sigaba e-mail encryption account. The following information will be needed to fulfill your request: first name, last name, e-mail address, facility name.

I just received a denial for the care I requested. Does this mean that I can't put my client in the level of care they need?

Answer: No. ValueOptions may have denied payment for care. ValueOptions does not deny the care itself. Members always have the right to appeal a denial.

What is the EQRO?

Answer: The External Quality Review Organization is a requirement by the federal government. The purpose of the EQRO is to make sure federal dollars are spent to improve member care related to access, quality and timeliness. For more information please go to <http://www.cms.hhs.gov>

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We have already scheduled some assessments prior to knowing these access standards were in place. What should we do about these appointments?

Answer: For any appointments made prior to 3/25/08, please put the data the client showed up for the assessment in all of the fields and mark the call as routine. For any appointments made after 3/24/08, please record access to care information and put the data in the KCPC when the client shows up for an assessment. Audit will be conducted by VO-KS to make sure there is a process for capturing this data.

Do we start collecting access type information now without any idea of what this means for services?

Answer: Access to care is about the urgency of the call, not about the services offered.

Access standards will impact the following:

- *Determining a caller's urgency level at the time of the call;*
- *Getting the client in within the required timeframes;*
- *Recording the date of the call, date the appointment was offered, date the appointment was accepted and urgency type in order to put it in the KCPC if the client shows for an assessment.*

If access for urgent clients requires the use of mental health crisis teams, will we be reimbursed? They are not CACs. What kind of services will they provide?

Answer: You can only bill mental health if the service provided is for mental health issues. If the service is, for example, for a substance abuse assessment, the person would need to be qualified to conduct the substance abuse assessment and ValueOptions would be billed. RADACs are available in every area and can conduct assessments when needed.

We contract with the Mental Health Consortium for after-hours phone coverage and their screening for access will require significant protocol work. How can we proceed when I am not sure what service options will be used?

Answer: Mental health providers have similar access standards (although timeframes are different) so THMC should be familiar with this process.

If a client calls in after hours and needs emergency treatment, he/she should be referred to an emergency setting.

If a client calls in after hours and needs an urgent appointment, a process will need to be in place to get the client access to an assessment within 24 hours.

If we get a call that is emergent, what does the documentation you require need to look like?

Answer: We are interested in this information and making sure members with emergent needs receive services. A second enhancement to the KCPC will be done at a later date in order to capture this data. No documentation is needed by providers at this time. We are working toward having the RADACs do assessments for anyone entering in an emergent setting such as a hospital.

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What does referred to a hospital mean? Do we tell them on the phone they need to go Salina Regional or the Hospital nearest them or is there more involved?

Answer: Yes. Advise the client to call 911 or direct them to the nearest emergent care facility such as a hospital.

If we get a call that is routine, what does the documentation you require need to look like?

Answer: The documentation would be client identifiable information such as name and date of birth, the date of the call, the date an appointment was offered, the date the client chose to have an assessment and the urgency type.

What is the time frame for a routine call?

Answer: The client should have an assessment within 14 days of his/her initial call.

We get referrals for appointments and never get to speak with the client. What do we do in those cases?

Answer: Take the date of the referral as the initial contact date.

We receive phone calls from parents wanting to schedule an appointment for their son/daughter. How can we determine urgency?

Answer: If the client is present during the call, you must speak with the client. If the client is not present, ask the parent the questions to determine urgency.

What questions are asked to by providers to see if a client call is emergent, urgent or routine?

Answer:

Emergent

Ask the client the following:

Are you in distress? (Are you having physical problems right now, or do you feel like you might hurt yourself or someone else?)

If yes, the caller would be transferred to a clinician for assistance, and the clinician will decide whether to rate the treatment need as Emergent, Urgent or Routine.

- If caller is determined to be at risk of self harm or harm to others, or is a detox risk, the member requires immediate assistance and intervention, and is referred to a hospital or detox setting. The need is rated as Emergent.

**VO is working out a process with the hospitals/RADACs to capture this information in the KCPC*

Urgent

Ask the client the following:

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Have you been drinking or gotten high within the last 24 hours, or do you plan to within the next 24 hours?

Are you currently hospitalized for alcohol or drugs, or have you been discharged within the past 24 hours from a hospital or residential setting where you received treatment for alcohol, drugs or mental health?

If yes, the caller would be considered to have an urgent need and the urgent appointment standards would need to be followed.

Need is also considered to be urgent for the following priority populations:

- Pregnant women;
- Women with dependent children;
- Individuals diagnosed with HIV;
- Intravenous drug users;
- Clients with special health care needs; (Co-occurring, SPMI, SED)
- SRS clients (Family Preservation, Foster Care, etc.); and
- Individuals who are involuntarily committed.

For Block Grant priority populations, the standards is 48 hours from initial call to assessment **IF** the client does not meet the need for a 24 hour urgent appointment

Routine

All other calls not considered emergent/urgent would be considered routine.

Do all facilities, even small outpatient providers need to have 24-hour coverage?

Answer: Yes. We need to provide coverage 24 hours a day in order to ensure the safety and security of clients.

What would count as having 24 hour coverage?

Answer:

- *Pagers only if the client receives a callback within 5 minutes;*
- *Staff person on call answering the phone who has the ability to determine the urgency of the call;*
- *Separate after hours number to call to access a person with the ability to determine the urgency of the call (the number must be in the Provider Directory);*
- *Having an agreement with another agency to take calls after hours;*
- *Assign on-call cell phones for after-hours.*

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Prevention, Education and Outreach (PE&O)

My information is not correct in the Provider Directory. What should I do?

Answer: It's very important for us to give the most updated version of the provider directories to our members. Twice/year we will verify all information for reprints of the provider directory and we will update the ValueOptions-Kansas website once/month. If your information changes, please contact Sheree.Marzka@valueoptions.com with the correct information. In order to maintain the accuracy of the provider directory, all requests for changes must be done in writing. Please make sure the contact number is the number you want members to call in order to access your services.

How do you get member handbooks and provider directories to the homeless?

Answer: When homeless people present for services, please provide them with a member handbook and provider directory and make a note in the KCPC that you gave them the information (needed for federal auditing purposes). If you do not have copies of the handbook and/or provider directory, please contact your provider representative.

What can we expect from the PE&O department?

Answer: The PE&O department is currently conducting a needs assessment in order to enhance, not replace, activities already in place in each community. If you have a need in your area that you think ValueOptions can help fill, please contact sheree.marzka@valueoptions.com. To date activities have included:

School pilot program, Drug Free Week

Creation of tip sheets including Holiday Tip Sheet, Pre-natal Checklist Tip Sheet and Pregnancy Aftercare Tip Sheet

Development of Jan – Mar Member Newsletter

Distribution of benefit reference cards to homeless shelters

We requested printed copies of the tip sheets but were told they were not available.

Why?

Answer: In order to keep up with demand, ValueOptions creates the tip sheets and distributes them electronically via the ValueOptions-Kansas website and e-mail. Printed tip sheets are reserved for onsite visits to homeless shelters, physicians offices and various community events.

General

There is no MCO that pays for fully allocated costs. Can this be done for Block Grant?

Answer: ValueOptions will forward this request on to the State for consideration. Thank you for your suggestion.

The onus is always on the provider to make calls and follow-up, even if the error was ValueOptions' fault. What can we do?

Answer: In order for ValueOptions to address issues, we need as many specifics about the situation that occurred as possible. This helps determine the appropriate intervention and action to prevent future problems. Please help us by documenting your issues and information to sheree.marzka@valueoptions.com for follow-up.

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I can call 3 different people and get 3 different answers. First, how do I know which answer is correct and second, why are people saying different things? Aren't your staff trained to give the same responses?

Answer: You should expect and receive the same (and correct) answer from staff on your first call. If this is not the case, please document the ValueOptions staff name, date/time of the call and member/issue you were calling about. Please forward the information to sheree.marzka@valueoptions.com and we will investigate your issue and take the appropriate action.

One of your staff members made some inappropriate comments on the phone. What can be done so this doesn't happen in the future?

Answer: Please write down the name of the person you spoke with as well as the date and time of the call. This information will allow us to follow up with the appropriate staff in order to make sure this does not happen again.

Does ValueOptions get to keep the money they save on patient care?

Answer: No. It would be a violation of the contract ValueOptions signed with the State of Kansas to keep any unspent money.

How do we make suggestions for community reinvestment dollars for Medicaid funds?

Answer: Please send an e-mail to Sheree.Marzka@valueoptions.com and the suggestions will be compiled and sent to the State for consideration.

Clinical

We aren't allowed to discharge someone to homelessness but ValueOptions won't pay for the client to stay in residential if they don't meet ASAM criteria for that level of care. I begin discharge planning from the first day but often it takes longer than the approved days to get the client a stable living environment because they don't have friends or family. What can we do in these situations? We see this as part of the ASAM criteria dimensions because without a stable living environment the client will most likely fail.

Answer: ValueOptions will take all 6 dimensions into consideration when making a level of care determination. It would be helpful if providers gave detailed information about where a member was living prior to getting treatment and why that is not a viable option upon discharge.

I sent in two files last week. The care manager said that failing a UA is not a reason for admission.

Answer: Clinical information on all 6 dimensions is taken into consideration when making a level of care determination. Lapse/relapse in and of itself may not indicate the need for a higher level of care. Information on other dimensions is needed in order to make a determination.

I had a pregnant woman who was denied treatment because she was "only" using marijuana. What is the ValueOptions policy for this priority population?

Answer: Clinical information on all 6 dimensions is taken into consideration when making a level of care determination. Regarding marijuana use specifically, ValueOptions will be looking for date of last use, recent usage patterns, relapse potential

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and consequences of use. The health of the pregnant woman and unborn child is, of course, be a consideration. Current policy is that when an initial assessment for a pregnant woman is completed, ValueOptions will authorize the level of care recommended by the assessor.

What do we need to say/document to make sure that youth get the level III.1 or III.5 services we recommend?

Answer: We authorize according to ASAM criteria and each case will be viewed independently.

Children often lie about their past history. The reviewer states that he/she thinks the client is lying but is still denied residential or intermediate care because of client self report. What can we say/document to get the level we think the client needs in these circumstances?

Answer: It is important that we not assume that such assumptions be explored. We suggest that you utilize collateral contacts to confirm an individual's alcohol/drug use or your other concerns. Your documentation of such contacts will assist in presenting a complete clinical picture of your client.

We send in our Release of Information (ROI)s but ValueOptions still hasn't released the case and it's been over a week. What can we do?

Answer: We make every effort to forward these files within 24 hours of your request. Please call ValueOptions at 1-866-645-8216 if you have not received the KCPC after 2 days.

We have a case where ValueOptions says we are approved to treat the client but still do not have the KCPC. What can we do?

Answer: When we approve a request the file should automatically return to you. If you don't have the KCPC file please call us at 1-866-645-8216 so we can manually forward the file to you.

CSRs are not being returned in a timely manner. We have been told that that ValueOptions isn't hitting the button to send the KCPC back to us. Is this what is causing the delay?

Answer: When we approve a request the file should automatically return to you. If you don't have the KCPC file please call us at 1-866-645-8216 so we can manually forward the file to you.

Case management and support services are often overlooked in the KCPC. This causes a delay because we don't know if they have been approved. When will this be fixed?

Answer: In the next State rollout, there will be a notification to care managers when there is more than one service ValueOptions voucher request. This should eliminate these issues.

By the time the Continued Stay Review (CSR) is sent back, 3 days have been lost and we can't ask to be authorized for those 3 previous days in the KCPC. What do we do to get paid for this time?

Answer: When you send in your next CSR, please add a notation to your clinical note regarding when the last CSR was returned to you by ValueOptions.

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When doing UAs for outpatient, the judge may throw the client in jail for 60/90 days. We don't count jail time as clean time but some of the ValueOptions care managers are counting these days. Why?

Answer: The care managers should not be counting jail time as clean time. Please be clear in your clinical notes that any "clean time" is actually jail time. If you find that a care manager still counts these days please call us at 1-866-645-8216.

ValueOptions has caused a shift toward more outpatient utilization rather than residential. As a result, we are seeing more people in outpatient coming back with positive UAs. We don't think this would have happened if they were approved to be in residential. What can we do?

Answer: If you believe one of your clients should be in level III services please send a KCPC with clinical information indicating the need for the requested level of care. Lapse/relapse is a part of recovery and ASAM criteria states that relapse in and of itself does not necessitate treatment at level III.

We feel like we are spending more time justifying and documenting ASAM criteria to get care approved than we are spending with patients. We feel like our justification hits all of the dimensions but we still get suggestions for a step down or lower level of care placement. What should we do?

Answer: The KCPC is based on ASAM criteria. It is a State requirement that information on all 6 dimensions be gathered on clients during assessments and that ASAM criteria be utilized when securing ongoing care. ValueOptions has offered 2 free ASAM criteria webinars trainings and will continue to be a part of the KCPC trainings where documentation of criteria is discussed (2 KCPC trainings per year per RADAC will be at no charge).

We are having significant KCPC issues. When will these be resolved?

Answer: KCPC issues really require more specific information. Some issues require State interventions while some issues ValueOptions can assist with.

There is no homeless shelter within 100 miles for our clients. What do we do in the middle of the winter when they don't meet ASAM criteria but don't have a place to live?

Answer: ValueOptions is working with the State on this issue. We are also in the process of compiling a list of community resources available across the State. Although homelessness alone is not a justification for keeping someone in treatment, please be sure to list this concern in the KCPC clinical notes for individual clients.

Is there a set schedule for Continued Stay Reviews (CSR)s? It seems like we have to do rejustification every 14 days. Can the time in between CSRs be longer? How much really changes in 14 days?

Answer: 14 days is the standard authorization period for level III.1 services and 7 days for level III.3/III.5. There is no plan to lengthen the authorization period. During the 14 or 7 days it is expected that clinical interventions will have had an impact on the client and we are requesting an update on the member's response as well as what the provider will be doing to address the member's current needs.

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Some drugs cause varying degrees of cognitive impairment in the brain. Depending upon the drug and impairment, treatment may need to be for longer periods of time. Is there any way to train care managers to take this into account when authorizing days?

Answer: ValueOptions does take the drug of choice into consideration, along with other conditions that cause cognitive impairment. If you believe that your client is so impacted, please elaborate on the issue in your clinical notes.

If someone relapses, why put the person back at the same level. Wouldn't it be better to move them to a higher level of care?

Answer: Lapse/relapse is a part of recovery and ASAM criteria states that relapse in and of itself does not necessitate treatment at a higher level of care.

Our staff was spending up to 40 minutes on the phone with ValueOptions trying to get authorization for a client. What can be done to shorten this time?

Answer: The average call length is between 6 and 8 minutes. It is very helpful when completing telephonic reviews when the caller has detailed information on all 6 dimensions. If you are finding that your clinicians are regularly spending 30 or more minutes on a call about one client please contact your provider relations representative or the ValueOptions Clinical Director, Amber Gaia.

Provider Relations

We are still having difficulty receiving our KCPCs. Our provider relations representative is trying to help but it's not working. What can we do?

Answer: Please contact customer service at 1-866-645-8216 for investigation, they can review information or get you to a clinical care manager to assist with KCPC issues.

We continue to receive denials on claims submitted? What is the process to get help? Our billing person works out of her home.

Answer: Please contact your provider relations representative to set up a meeting with the billing staff for face to face assistance or to set up a conference call to assist with billing questions. Providers can also contact customer service at 1-866-645-8216 and receive assistance from the claims customer service department.

Some of our claims are denying because the member is not eligible for Block Grant but we are not submitting the claims under the member's block grant id. What happened?

Answer: Please contact your provider relations representative to set up a face to face meeting with your staff or to set up a conference call to assist with questions. Providers can also contact customer service at 1-866-645-8216 and receive assistance from the claims customer service department.

How can we check member eligibility under ProviderConnect?

Answer: You must have identifying information for member search. You can also contact customer service at 1-866-645-8216 in identifying members.

We have had to wait several weeks for clean claims. What is going on? We know ValueOptions has 30 days to pay claims but this is causing smaller providers to have a severe cash flow issue.

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Answer: Please provide specific details to regional provider representatives. It is ValueOptions contractual agreement that clean claims should be processed within 30 days of receipt.

We would like to reconcile authorizations to billings. Is there a way to get reports to help us do this?

Answer: All authorizations are listed in ProviderConnect. Please contact your regional rep for alternative reconciliation methods.

Can we get reports by procedure code and submission date rather than by client? This will help us reconcile our billings.

Answer: All claims are processed at the member level and the EOB reflects other requested data. The claim number will reflect the date the claim was received at ValueOptions.

We need ProviderConnect training. How can we request this?

Answer: Contact your provider relations representative for assistance.

Is it true that what we bill for in October could take until the next year for reimbursement?

Answer: ValueOptions tries to pay all clean claims within 30 days of receipt. There is a financial penalty assessed by the State against ValueOptions if clean claims are processed late.

Why do we have to wait for private insurance to deny before payment is issued (Third Party Liability)?

Answer: It is important for members to utilize all insurance. Medicaid and Block Grant are payers of last resort. If the EOB has been received for services please forward that to ValueOptions for appropriate claims processing.

We've done an assessment on a member that does not meet ASAM criteria for treatment. How do we get reimbursed for doing the assessment?

Answer: Please submit billings for assessments (H0001) with a diagnosis code of V71.09 if the member does not meet medical necessity for treatment.

What do I do if a client is diagnosed with a Co-Occurring Disorder? Who do I bill?

Answer: If the client is co-occurring, list the diagnosis for which the client is being treated for first. For example for billing purposes, if a client is abusing substance and has a diagnosis of depression, list the depression diagnosis first on the claim if the person was seen that day for his/her depression. If the person was seen that day for substance abuse treatment, list the substance abuse diagnosis first.

For Residential services, we were told the following:

If a client comes in late in the evening, we can bill one full day because a bed was used. If the client then leaves early in the morning the next day, we can bill another full day because a bed was used for a total of two days billed. Is this correct?

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Answer: No. You can bill for the evening but not for the morning. ValueOptions would only pay for one day.

Finance

How do providers know when they have hit their Block Grant financial targets by vendor? We used to get a report from the State and with ValueOptions we don't get anything.

Answer: Although ValueOptions is not contractually obligated to provide this reporting, we will respond to requests for information and assistance. For specific questions about Block Grant financial targets, please contact Finance.