VALUEOPTIONS OF KANSAS
Provider Handbook Supplement

A procedural guide for participating providers

2007

VALUEOPTIONS KANSAS

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INTRODUCTION

Welcome

Welcome to the ValueOptions of Kansas provider network! As a participant in the ValueOptions of Kansas provider network, you join a progressive program dedicated to providing quality care for Kansas Members. We thank you for your participation in our provider network, and we look forward to a long and rewarding relationship as we work together to provide responsive treatment to our Members.

This manual was developed as a supplement to the Participating Provider Handbook located on our Provider site at www.valueoptions.com to answer questions specific to ValueOptions of Kansas and to explain how we assist with the coordination of the delivery of chemical dependency/substance abuse care to covered individuals.

The manual begins with a ValueOptions of Kansas overview and describes our policies and procedures as it pertains to our administrative processes and covered services. Your adherence to the guidelines contained in this manual will assist you in obtaining timely service authorizations and claims reimbursement. Also included is a glossary of frequently used terms. Required forms are accessible via the Forms section of the Provider site.

If you have any questions or comments about the material in this guide, feel free to contact our National Provider Line at (800) 397-1630, Monday – Friday, 8 a.m. – 5 p.m. EST.

Purpose

The State of Kansas, Department of Social and Rehabilitation Services (SRS) selected ValueOptions, Inc. to serve as a Substance Abuse Prepaid Inpatient Health Plan (SA-PIHP) Contractor to manage statewide substance abuse (SA) services for Members eligible for Medicaid (T-XIX) and Members eligible for Substance Abuse Prevention and Treatment (SAPT) Block Grant-funded substance abuse services.

Background

T-XIX-funded substance abuse services and substance abuse services funded by other sources such as the SAPT Block Grant will continue to be overseen by SRS at this time. SRS, through its Health Care Policy Division of Addiction and Prevention Services (AAPS) funds a comprehensive substance abuse treatment infrastructure, guided by evidence-based practices, data-driven processes, and outcomes-based planning and evaluation. To facilitate its oversight, AAPS has developed an information system, called the AAPS Integrated Data System. Through this system, AAPS licenses substance abuse providers, provides information regarding grants, reviews the medical necessity of services against the Kansas definition of medical necessity and the requested level of care against ASAM criteria as contained in the Kansas Member Placement Criteria (KCPC) System, pays claims, captures the National Outcome Measures as required by Substance Abuse and Mental Health Services Administration (SAMHSA), and monitors quality of care. Providers use the AAPS

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Integrated Data System to create electronic records, request treatment, and bill for substance abuse services provided. ValueOptions of Kansas will continue to use the AAPS Integrated Data System and integrate the use of ValueOptions of Kansas managed care information systems.

AAPS has traditionally funded Regional Alcohol and Drug Assessment Centers (RADACs) to provide statewide on-site assessment and referrals to the treatment service that best meets the Member's needs. RADACs currently conduct assessments, referrals, outreach and care coordination services. Although the RADAC's role in assessment, referral and care coordination on behalf of AAPS and SAPT-funded priority Members shall continue through a subcontracted relationship with ValueOptions of Kansas, the RADACs' role in Utilization Management (UM) and prior authorization of care will cease on July 1, 2007.

Evolutionary Process

The SA-PIHP model is the next step in the evolution of the Kansas substance abuse system. The SRS vision for the substance abuse program, which is informed by the system's stakeholders, includes:

a. A Member and community-centered philosophy;

b. System collaboration with medical, mental health and substance abuse prevention delivery systems;

c. System collaboration with other agencies such as child welfare and the criminal justice system;

d. Integration of technology and resources;

e. Promotion of fiscal responsibility by leverage of resources and diversified funding;

f. Availability and accessibility to the continuum of care in every region; and

g. Promotion of continuous quality improvement based on data, research and outcomes.

Using value-based purchasing strategies, the State of Kansas intends to increase access to high quality substance abuse treatment which is well-coordinated with other physical health and mental health services and encourage the development of a managed system of care that promotes long-term health and wellness under the authority of a 1915(b) Waiver.

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ValueOptions of Kansas Service Center

The ValueOptions of Kansas Service Center (VO-KS) is located in Topeka, Kansas. The VO-KS is established to assure that ValueOptions will become an effective component of the Kansas substance abuse delivery system. The service center will have a full executive management team headed by a Chief Executive Officer and a staff of more than 30 people.

The office is located at the following address:

ValueOptions of Kansas Service Center
Commerce Bank
100 SE 9th Street, 5th Floor
Topeka, KS 66612

This location serves as the hub for our clinical and administrative activities. To streamline operations, ValueOptions delegates operational authority of our senior management staff located in Kansas. The senior management staff is accountable for ensuring that ValueOptions of Kansas operations are well run.

Online Provider Services

These services are designed to give providers easy and no cost access to valuable information, tools and resources designed specifically for ValueOptions' providers. ValueOptions of Kansas providers have access to the following online services at www.valueoptions.com:

- **ProviderConnect:** This is a handy tool that allows providers to submit and review claims, check eligibility, update practice profiles, request inpatient and outpatient care online, view correspondence. ProviderConnect is easy to use, secure and available 24/7. (Please note that some of the functions ProviderConnect has to offer may not be available due to account/plan limitations.)
- **ValueOptions of Kansas Web site:** Network specific information is accessible from the ValueOptions Provider site. This Web site houses information specifically for ValueOptions of Kansas network providers and includes upcoming trainings, the handbook supplement, and other important information and updates.
- **Participating Provider Handbook:** This comprehensive online handbook offers a quick, easy-to-use reference for most provider questions. Sections include; Administration, Clinical Criteria, Treatment Guidelines, and an extensive Glossary of Terms. The online handbook is user friendly, easy to read and always up-to-date. ValueOptions of Kansas providers are encouraged to review the Participating Provider Handbook to gain a better understanding of ValueOptions' policies and procedures, services, and administrative processes. The ValueOptions of Kansas Provider Handbook Supplement answers questions that are specific to the ValueOptions of Kansas provider network; it does not replace the ValueOptions Participating Provider Handbook.

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- ***The Valued Provider* Newsletter:** View the newsletter online for important information and updates regarding clinical matters, administrative processes, educational opportunities, ValueOptions' policies, etc.
- **Achieve Solutions:** This Web site provides comprehensive information and practical recommendations related to addiction and recovery, mental and behavioral health, medications, life events, and daily living skills. It is accessible through the VO-KS website and includes a broad range of content, such as interactive quizzes and online skill building modules. It is an excellent resource for a provider's own professional reference. Providers can print off articles to support work with individual members and family Members.
- **Forms:** Current forms are posted online and may be downloaded. ValueOptions of Kansas providers are encouraged to download, complete and send ValueOptions the Change of Address and W-9 forms to ensure the most up-to-date information is on file.
- **Compliance:** It is the policy of ValueOptions to comply with all local, state, and federal laws governing its operations; to conduct its affairs in keeping with the moral, legal and ethical standards of our industry; and to support the government's efforts to reduce healthcare fraud and abuse. Providers can access articles, frequently asked questions, tools, and resources to stay abreast of ValueOptions' policies and programs by selecting the Compliance page.
- **Education Center:** ValueOptions offers many educational opportunities for its providers. Find articles on various topics. Search for a Provider Forum (online, telephonic, and onsite) and register online. Provider Forums offer a wealth of information about ValueOptions processes, continuing education credits, and hot topic presentations by qualified speakers in the behavioral healthcare industry. There is no cost to attend. The Education Center also offers many other tools and resources, such as, but not limited to, the following:
    - Preventive Health Member Materials: Find educational articles, screening tools, and tips on Depression, ADHD, Postpartum Depression, Anxiety and more. Great information to share with Members.
    - The CAGE: An online, self-scoring version of the CAGE (Cut, Annoyed, Guilty, Eye-Opener) self-screening questionnaire. The CAGE alcohol screening tool is brief (four questions), easy to use, and helps determine if an individual has a potential issue related to alcohol use. The CAGE is a validated instrument and an established standard of assessment. It is anonymous and can be administered in an interview with a member.
- **Contacts:** ValueOptions takes providers' requests, comments, and suggestions seriously. The Contacts section of the Web site provides important phone numbers, mail and email addresses.
- **View Practice Profile:** This option displays the current information ValueOptions has on file for all network providers. Providers may update profile information via ProviderConnect or by submitting a Change of Address Form.

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ELIGIBILITY

Categories of Eligibility for T-XIX

T-XIX beneficiaries who will be eligible for substance abuse services include:

Population	Population Codes
AFDC adults and children	30-36
Poverty Level Eligible	43-46
Supplemental Security Income	10-12
Medical Support	20-22
Working Disabled	26
Medically Improved	27
Medical Assistance	40-42
Breast/Cervical Cancer	75
Adoption Support	67
Foster Care	60-69
MA Child Institution	73

T-XIX Beneficiaries Not Eligible for the Contract:

All T-XIX beneficiaries are automatically enrolled for provision of covered T-XIX services under this Contract except for the following excluded eligibility categories:

a. T-XIX beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

b. T-XIX beneficiaries who receive services through the S-CHIP program. Kansas has a stand-alone S-CHIP program.

c. Sixth Omnibus Budget Reconciliation Act of 1986 (SOBRA) eligibles for an emergency condition only.

d. Individuals participating in the refugee resettlement program.

e. Beneficiaries who have an eligibility period that is only retroactive.

f. Beneficiaries who reside in an Adult Care Home.

g. Beneficiaries who reside in a State Institution.

h. Beneficiaries who have not yet met spend-down requirements.

i. Beneficiaries who are being treated in a Psychiatric Residential Treatment Facility (PRTF).

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SAPT Block Grant and Eligibility

SRS published the Treatment Funded Members Eligibility Guidelines in October 2003, (Attachment E) that are applicable to eligibility for the SAPT Block Grant funds. This document identifies the following eligibility guidelines:

a. Documented State of Kansas resident.
b. Income is determined to be at or below 200% of Federal Poverty Guidelines (FPG)

Exceptions to the above:

a. Members age 18 and under are not subject to a sliding fee scale up to 200% of FPG.
b. Social Detoxification providers are exempt from determining income or residency guidelines. Social Detoxification is considered to be an "on demand" service for any person needing that service.

The SRS Memorandum of Understanding (MOU) with the Kansas Department of Corrections (KDOC) states that SAPT Block Grant funds are available for substance abuse treatment of offenders on post-release status who meet the eligibility guidelines. It also stipulates that offenders who are assessed to be of high risk for public safety or those identified as sex offenders are ineligible for SAPT funds.

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SERVICES

Covered Services

Funded Services

The table below identifies covered services by fund source.

	T-XIX Funded Services for T-XIX Members		SAPT Funded Services for SAPT-eligible Members
	State Plan	Waiver	
Level I - Outpatient			
Individual Counseling	X		X
Group Counseling	X		X
Level II - Intensive Outpatient Treatment/Partial Hospitalization			
Intensive Outpatient	X		X
Level III - Residential/Inpatient Treatment			
3.1 Reintegration		X	X
3.5 Intermediate		X	X
3.7 Social Detoxification			X
Level IV - Medically Managed Intensive Inpatient Treatment			
Acute Detoxification	X		
Inpatient Treatment	X		
Auxiliary Services			
Assessment/Referral	X		X
Case Management	X		
Person-Centered Case Management (PCCM)			X
Support Services			X
Dependent Children			X

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Coverage and Payment for Emergency Services of T-XIX

ValueOptions of Kansas is responsible for coverage and payment of emergency services and post-stabilization services as required in 42 CFR 438.114.

a. A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.

b. The attending emergency physician, or the provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized from an emergency medical condition for transfer or discharge from an emergency room, and that determination is binding on the ValueOptions of Kansas.

c. ValueOptions of Kansas shall not deny payment for treatment obtained when an Member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition.

d. ValueOptions of Kansas shall not deny payment for treatment obtained when a ValueOptions of Kansas clinical care manager instructs the Member to seek emergency services.

e. ValueOptions of Kansas shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. However, the diagnoses and/or symptoms must be related to a covered substance abuse condition as defined in your provider agreement.

f. Emergency services for covered conditions shall be reimbursed for Member regardless of whether authorized in advance or whether the provider of the service is a part of the service network.

g. For emergency services provided to a Member by a network or non-network provider when substance abuse diagnoses are the primary condition, ValueOptions of Kansas shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying ValueOptions of Kansas of the Member's screening and treatment within ten calendar days of presentation for emergency services.

h. For emergency services provided for substance abuse reasons by a network or non-network provider, ValueOptions of Kansas shall:

   i. provide a minimum triage fee to the hospital regardless of whether the facility notifies ValueOptions; the triage fee shall be no less than is paid through the fee-for-service T-XIX program;

   ii. reimburse the facility for emergency services provided, contingent upon the facility's compliance with notification policies; and

   iii. reimburse non-network providers an emergency room fee which is no less than the minimum payment which would be made to a network provider.

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Services NOT Covered

Besides substance abuse services managed by ValueOptions of Kansas, other health and social services are available to Members. The following services **are not** the responsibility of ValueOptions of Kansas except as related to coordination of services:

a. Medical (Physical Health) Services — T-XIX of the Social Security Act, referred to as Medicaid, provides medical assistance for certain individuals and families with low incomes and resources. Medicaid became law in 1965, as a jointly funded cooperative between the Federal and State governments to assist States in the provision of adequate medical care to eligible needy persons. T-XIX services in Kansas are provided through a primary care case manager (HealthConnect Kansas), or through a capitated PIHP (HealthWave 19), or via fee-for-service for persons on an HCBS waiver, in long term care, or in a voluntary population (e.g., SSI children age 21 years and under, Title V children age 21 years and under, and Native Americans). S-CHIP (HealthWave 21), is a separate capitated program with mental, behavioral, and substance abuse services provided by a separate contractor. Limited T-XIX behavioral health services are provided through HealthConnect and HealthWave 19. T-XIX pharmacy services are also provided through fee-for-service, HealthConnect, and HealthWave 19.

b. Mental Health Services — Most T-XIX mental health services will be delivered through and managed by a non-risk, Prepaid Ambulatory Health Plan (PAHP).

c. Prevention Services — There are thirteen Regional Prevention Centers that provide comprehensive support for the six core substance abuse prevention strategies established by the Center for Substance Abuse Prevention: Information Dissemination, Problem Identification and Referral, Alternative Activities; Education, Community-based Processes and Environment Strategies.

d. Temporary Assistance to Families (TAF) Funded Programs - SRS receives TAF funding to provide TAF cash recipients experiencing substance abuse problems services such as assessment, education, pretreatment counseling, strength based intensive case management, maintaining compliance with TAF core work requirements, and care coordination. This program is known as Solutions Recovery Care Coordination. SRS contracts with RADACs and Regional Prevention Centers to provide Solutions Recovery Care Coordination services within SRS offices across the state.

e. 4th Time Driving Under the Influence (DUI) Treatment program — Under KSA 8-1567, persons that are convicted of a 4th DUI must spend a minimum of 90 days in jail up to a maximum of 1 yr. As part of sentencing, they must complete an inpatient or out-patient treatment program and follow all recommendations set for one year. SRS is responsible for the administration of the program and the Kansas Department of Corrections reimburses SRS for treatment costs. SRS contracts with RADACs for assessment, care coordination and UM services and with licensed programs for treatment services.

f. Medication-Assisted Treatment — There are five methadone clinics in Kansas (located in the two largest urban areas of the State), that provide non-residential services that support the concept of long-term methadone maintenance or other medication assistance to prevent return to opiate abuse. ValueOptions shall ensure coordination of care for opiate-dependent individuals to include the provision of traditional treatment services concurrent with medication assisted treatment when medically indicated.

Service Planning and Service Planning Oversight

Required Elements of Service System Development and Coordination

In case of a dispute regarding whether a service is medical, mental health or substance abuse, SRS will serve as the final decision maker, first using the list of covered and required services and then considering the service codes that were used as the basis for the development of the original capitation payment.

For youth who are receiving substance abuse treatment services, some similar services are available through other funding streams such as the child welfare or juvenile justice systems. ValueOptions of Kansas, the youth's case manager(s), the youth's natural, foster, or adoptive parents as appropriate and legally allowable, and others involved in providing services to the youth are required to plan jointly for both the delivery and funding of services appropriate to the needs of the youth. In case of a dispute regarding whether a service is the appropriate funding responsibility of ValueOptions, child welfare or juvenile justice systems, SRS will serve as the final arbiter, based on the following:

a. whether the service is directed towards achieving youth safety and permanency or community safety, or whether the service is directed towards addressing the youth's substance abuse treatment;
b. considering the list of covered and required services; and
c. considering the service codes that were used as the basis for the development of the original capitation payment.

Transportation for T-XIX Members to medically necessary substance abuse treatment appointments is the responsibility of HealthWave XIX (for Members enrolled in managed care) or the KHPA (for fee-for-service). ValueOptions is responsible for coordination with HealthWave XIX or KHPA for T-XIX Members.

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Debarment and Suspension

As part of the Code of Federal Regulations (45 C.F.R. Part 76), all governmental entities receiving funding from the Federal Government must participate in a government wide system for non-procurement debarment and suspension. A person or entity who is debarred or suspended shall be excluded from Federal financial and non-financial assistance and benefits under Federal programs and activities. Debarment or suspension of a participant in a program by one agency shall have government wide effect. The Secretary of SRS is authorized to impose debarment. Before any person or entity enters into an agreement, grant or contract with ValueOptions or SRS, the "Excluded Parties Lists" (located at the web site https://epls.arnet.gov) shall be researched for potential debarred persons or entities.

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UTILIZATION MANAGEMENT

Overview

The philosophy at ValueOptions is to provide a care management system that offers easy and immediate access to the most appropriate, quality substance abuse services for members. In addition, ValueOptions has adopted a utilization management system that supports providers in delivering clinically necessary and effective care with minimal administrative barriers.

The utilization management program encompasses management of care from the point of entry through discharge. ValueOptions believes in macro-management of care as much as possible through the use of objective, standardized, widely-distributed clinical protocols and outlier management programs. Intensive utilization management is reserved for high-cost, highly restrictive levels of care and cases that represent clinical complexity and risk.

ValueOptions' Clinical Case Managers (CCMs) base their review on clear and concise criteria developed by the American Society of Addiction Medicine PPC-2R and adopted by ValueOptions to guide level of care, treatment and length of stay determinations. CCMs are trained to match the needs of members to appropriate services, levels of care and community supports. This requires careful consideration of the intensity and severity of clinical data presented, with the goal of quality treatment in the least restrictive environment. The clinical integrity of the utilization management program ensures that members who present for care are appropriately monitored and that comprehensive reviews of all levels of care are provided. The documentation of the clinical criteria is placed in the Kansas Clinical Placement Criteria Screening Instrument (KCPC-SI) and forwarded to ValueOptions via the ***"Service Request/Authorization"*** Screen in the KCPC and submitting the information electronically over Citrix in the KCPC.

Those cases that appear to be outside of best practice guidelines are referred for specialized reviews. These may include evaluation for intensive care management, clinical rounds, Peer Advisor review or more frequent CCM review.

ValueOptions has designed a system of care that is based on principles of quality care, and one that maintains flexibility in meeting the needs of diverse populations, communities and customers. ValueOptions' system:

- Provides easy and early access to appropriate treatment;
- Works collaboratively with providers in delivering quality care according to accepted best-practice standards;
- Addresses the needs of special populations, such as children and the elderly;
- Identifies common illnesses or trends of illness;
- Targets high-risk cases for intensive care management; and
- Emphasizes prevention, education and outreach.

Organizational Structure and Staff Accountability

ValueOptions places a high value on the selection, training and performance evaluation of clinical staff performing utilization management services. All staff involved in clinical care management activities holds terminal degrees and licensure in their field. ValueOptions' physician Peer Advisors (PA) and Medical Directors are experienced, senior level clinicians, many of whom remain active in private practice. The majority are Board-certified in their specialty areas and are required to maintain a current knowledge of behavioral health research findings and nationally recognized practice guidelines. Licensed Clinical Psychologists provide peer reviews for psychological testing and outpatient treatment.

The clinical care management staff at our call centers is multidisciplinary and able to manage care in all general psychiatric, psychiatric subspecialty and substance abuse areas. ValueOptions requires that CCM's be fully licensed mental health professionals with a minimum of three years prior clinical experience in a mental health/substance abuse setting providing direct member care. First-level reviews are generally conducted by nurses (RN or MSN), masters-level, or doctoral-prepared licensed behavioral healthcare clinicians. These clinicians complete all types of reviews for higher levels of care and complex outpatient reviews, including precertification, concurrent review, discharge planning and care management.

All providers are required to comply with the review process.

Medical Necessity

It is ValueOptions' policy to authorize payment only for services that are medically necessary and provided for the identification and treatment of a member's illness.

The State of Kansas department of Social and Rehabilitative services has defined MEDICAL NECESSITY as a clinical intervention for an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:

a. Authority. The clinical intervention is recommended by the treating clinician and is determined to be necessary by the Secretary or the Secretary's designee.

b. Purpose. The clinical intervention has the purpose of treating a medical condition/substance abuse disorder.

c. Scope. The clinical intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the client.

d. Evidence. The clinical intervention is known to be effective in improving health outcomes. The scientific evidence for each existing intervention is to be considered first and, to the extent possible, be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care are to be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions are to be based on expert opinion. Coverage of existing interventions shall not be denied solely on the basis that there is an absence of conclusive scientific evidence. Existing interventions may be

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deemed to meet this regulation's definition of medical necessity in the absence of scientific evidence if there is a strong consensus of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of those standards, convincing expert opinion.

e. Value. The clinical intervention is cost-effective for this condition compared to alternative interventions, including no intervention. The term "Cost-effective" shall not necessarily be construed to mean lowest price. An intervention may be clinically indicated and yet not be a covered benefit or meet the definition of medical necessity. Interventions that do not meet the definition of medical necessity may be covered at the choice of the Secretary or the Secretary's designee. An intervention is to be considered cost-effective if the benefits and harms relative to costs represent an economically efficient use of resources for members with this condition. In the application of this criterion to an individual case, the characteristics of the individual member is to be determinative. "Medical necessity in psychiatric situations" means that there is medical documentation that indicates that the person could be harmful to himself or herself or others if not under psychiatric treatment or that the person is disoriented in time, place, or person.

Standard Timelines for Determination of Medical Necessity

a. Acuity of Need — Members with emergency needs shall be referred to services immediately. Members with urgent, non-emergency needs shall be assessed within twenty-four hours of a request for services. Members with non-urgent needs shall be assessed within fourteen calendar days of the date the services are requested.
b. Urgent, non-emergency services for member shall be delivered within forty-eight hours of the date/time of assessment. Treatment services for non-urgent needs shall be delivered within fourteen calendar days of the date of assessment.
c. Special Service Needs — Members who are pregnant women, regardless of member status, (T-XIX or SAPT funded) shall be provided treatment within seven calendar days of an assessment. Members who are intravenous (IV) drug users shall be admitted no later than fourteen calendar days after an assessment, or 120 calendar days after the date of such request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than forty-eight hours after such request.
d. Geographical Standards — Accessibility for Members should be within the community norm for urban and rural populations. The availability of types of substance abuse programs will vary from area to area, but access problems may be especially acute in rural areas.

Clinical Criteria

The clinical criteria used by ValueOptions to make admission, level of care and continuing treatment decisions reflect ValueOptions' philosophy and clinical values. These criteria are assessed and revised at least annually by ValueOptions' Corporate Executive Medical Management Committee (EMMC) and Clinical Advisory Committees.

Sources for the Kansas criteria is:

- The American Society of Addiction Medicine standards (ASAM);

ValueOptions has also adopted for use the ASAM PPC-2 criteria published by the American Society for Addiction Medicine (ASAM).

Treatment Guidelines

In addition to clinical criteria, ValueOptions has a set of Diagnoses-Based Treatment Guidelines. These guidelines are used in collaboration with providers to help guide appropriate and clinically effective care for a variety of complex psychiatric conditions. These guidelines represent standards of best practice for treating these complex conditions and can be referred to by Clinical Care Managers (CCM) and Peer Advisors (PA) during reviews. ValueOptions seeks input from providers, consultants, and other expert clinicians to develop some of the guidelines, but for the most part ValueOptions generally adopts guidelines existent in the professional literature such as those developed by the APA (e.g., Bipolar, Major Depression, Schizophrenia, Eating Disorder and ECT).

Access to Care/Referral Decision

ValueOptions' care management system provides multiple channels of access to care for members. Ease of access to appropriate care is central to our philosophy and clinical values. A member or provider may access the care system through any of the following avenues:

- 24-hour toll-free emergency care/clinical referral line
- Direct certification of all levels of care through referral by a ValueOptions' CCM
- In-person evaluations by network providers with assessment completed in the KCPC Web-based application
- Emergency services through freestanding psychiatric hospitals, medical hospitals with psychiatric units, emergency rooms or crisis response teams

Prior to initial determination of medical necessity, the CCM or customer service staff checks the member's eligibility status and benefit plan. If eligibility information is not available, in non-urgent/emergent situations the CCM will complete the screening assessment and pend the certification awaiting eligibility verification.

CCMs will work with members who are in need of urgent/emergent care regardless of eligibility status.

If a member is no longer eligible for benefits, the CCM will refer the member to appropriate community supports and programs, such as local or state-funded agencies or facilities, sliding scale discounts for continuation in outpatient therapy, or explore benefit exchanges with the insurer/payer. This coordination is intended to appropriately transition the member to other care and guard against patient abandonment.

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If a call is received from a member requesting care, the CCM conducts a brief screening to assess whether there is a need for urgent or emergent care. Wherever possible, potential AAPS funded members will be referred to a RADAC for AAPS screening and eligibility. ValueOptions' staff makes referrals to appropriate network providers, taking into account member preferences such as geographic location, hours of service, cultural or language requirements, ethnicity, type of degree the provider holds and gender.

Review of Inpatient or Higher Levels of Care

All inpatient and alternative level of care programs (this does not include outpatient therapy rendered in a provider's office or outpatient therapy in a clinic or hospital setting) will be subject to the review requirements described in this section. Prior to beginning treatment, the provider must contact ValueOptions:

- For notification
- To confirm benefits and eligibility
- To provide clinical information regarding the member's condition and proposed treatment
- For authorizations or certifications

CCMs/Referral Line Clinicians are available 7 days a week, 24 hours a day, 365 days a year to provide assessment and referral and conduct certification review. Except for in cases where the service is classified as "On-Demand", Precertification is the preferred type of review for higher levels of care; however, providers are expected to ensure the safety of members and may request certification of emergency care within 24 hours of an admission to an inpatient unit. Precertification review is conducted with the requesting provider or his/her delegate, and decisions are based on ASAM clinical criteria for the specified level of care. If a course of treatment is determined to be medically necessary, the certification will be for a specific period of time and level of care commensurate with the member's clinical condition. If prior to the end of the initial or any subsequent certification, the provider proposes to continue treatment, he or she must call ValueOptions for a review and recertification of medical necessity. It is important that this review process be completed more than 24 hours *prior* to the end of the current certification period.

The CCM conducts the continued stay review (CSR) with a focus on continued severity of symptoms, appropriateness and intensity of treatment plan, member progress and discharge planning. This is accomplished by reviewing the CSR summary in the KCPC and when indicated, in discussions with the provider or appropriate facility staff. The clinical information is documented and certified according to ASAM clinical criteria in the KCPC. Cases not meeting clinical criteria require Peer Advisor (PA) intervention via the peer review process. Any questionable or absent treatment plans, discharge plans or questions related to the quality and appropriateness of care being delivered are also referred to a Peer Advisor for review.

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Clinical Review Process

Our partnership with providers is dependent upon a cooperative effort to review care prospectively. Providers must notify ValueOptions through the KCPC or by phone for Inpatient Services prior to admitting a member to any level of care with the exception of "On Demand Services" such as services to pregnant women or women with children and for social detoxification. Criteria for admission to "On Demand" Services will be established after admission through the submission of the KCPC to ValueOptions for review. In all cases, providers are encouraged to contact ValueOptions by phone, KCPC, or through Provider Connect prior to initiating any treatment to verify member eligibility and preauthorization requirements.

When a request for services is received, once it is established that the member is eligible for benefits under the identified plan, the CCM gathers the required clinical information, references the appropriate criteria set, and determines whether the requested care meets medical necessity criteria. The CCM may certify levels of care and treatment services that are specified as available under the specific benefit plan (e.g., acute inpatient, residential, partial hospitalization, intensive outpatient, or outpatient). Care is certified for a specific number of services/days for a specific time period. CCM's have some flexibility in the certification limit, based on an individual member's clinical needs and provider characteristics.

Kansas Authorization Timeframes:

Utilization Management Guidelines

Service	Authorization Method	Unit	Initial Authorization timeframe
Level IV Hospital Based Detoxification Service & Residential Inpatient Services	Telephonic Review And KCPC Assessment	Day	3 – 7 days
Level III.2-D Social Detox	Review of KCPC Assessment submitted while member is in Social Detox	Day	5 – 7 days (This is an on demand service with the request submitted to VO with a minimum the first 3 dimensions of the KCPC completed)
Level III.3/III.5 Residential Intermediate Services	Review of KCPC followed by Telephonic Review	Day	7-14 days with CSR based on Medical Necessity up to 14 days
Level III.1 Reintegration Services	Review of KCPC followed by Telephonic Review	Day	14 days with CSR based on Medical Necessity up to 30 days
Level II.1 Intensive Outpatient Services	Review of KCPC	Day	Adults – 18 days authorized for a 10 week period to accommodate delayed start of treatment. Youth – 12 days authorized for a 10 week period to accommodate delayed start of treatment.

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Service	Authorization Method	Unit	Initial Authorization timeframe
			CSR timeframes based on medical necessity.
Level I Outpatient Services Includes Individual and Group Sessions	Review of KCPC	Unit	40 units (hours) of treatment over 16 weeks to accommodate delayed start of treatment. Concurrent review timeframes based on medical necessity.
Other Services Medicaid Case Management*	KCPC Assessment	Unit	40 units for every 12 weeks of treatment.
Person Centered Case Management*	KCPC Assessment		40 units for every 12 weeks of treatment.
Overnight Boarding rate for each child when child is present with Mother who is in level III services	KCPC Assessment	Day	One day for each day in level 3 treatment services when the child is present with mother.
Support Services *	KCPC Assessment	Unit	40 units for every 12 weeks of treatment.

**In regards to the "Other Services" section of the Utilization Management Guidelines, if you are requesting any of these services in addition to a main modality of care (i.e. Reintegration, Outpatient etc.) the service periods must match and therefore the units authorized may be adjusted to accommodate the primary modality of care.*

As indicated above, ValueOptions' policy is to prospectively review and approve all requests for services. We recognize that under some circumstances providers may deliver care before requesting a review by ValueOptions. When a provider requests a review for services that have already been delivered (retrospective review), ValueOptions will first determine whether such a retrospective review (e.g., emergency admission, members failure to indicate appropriate benefit coverage) is necessary and appropriate, and if so, may request needed medical records from the provider.

In cases where a retrospective review request is not justified, services may be reviewed and administratively denied. Administrative exceptions to this policy may be made for extenuating circumstances, determined on a case-by-case basis, or based on contractual requirements. If the admission meets the criteria for emergency admission, a medical necessity determination can be obtained retroactively within 24 hours of the admission.

Review Format

The medical necessity determination process is driven by the ASAM PPC-2R criteria contained in the KCPC system. The provider must submit the KCPC evaluation and service request to ValueOptions for the initial authorization and for all Continued Stay reviews. Upon receipt of the KCPC, a ValueOptions Care Manager will review the assessor's submitted KCPC and any associated

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releases for medical necessity. When necessary the care manager will complete a telephonic review based on the KCPC information and summary submitted to ValueOptions. Transfers from Levels, Open Continued stay reviews, Continued stay reviews, and Initial Assessments will all be managed by ValueOptions with appropriate file transfers completed based on the submission of the necessary releases of information through the KCPC and Provider Connect.

Ensuring Safety Through Adequate Discharge Planning for Youths

No youth Member who has been receiving substance abuse treatment services in a twenty-four hour treatment setting should be discharged from that setting until a discharge plan has been developed that provides appropriate follow-up care and treatment which is available and accessible to that Member. A safe and appropriate living arrangement shall be an integral part of that discharge plan. The discharge plan shall be implemented at the point of discharge from the twenty-four hour treatment setting.

Discharge planning should occur at the point of admission to a twenty-four hour treatment setting and Provider shall identify as early as possible the need for involvement of the court or other agencies.

Ensuring Safety Through Adequate Discharge Planning for Adults

No adult Member who has been receiving substance abuse treatment services in a twenty-four hour treatment setting should be discharged from that setting until a discharge plan has been developed which provides appropriate substance abuse follow-up care and treatment that is available and accessible to that Member. If a Member leaves against medical advice, the Provider shall not be held responsible for this requirement.

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AUTHORIZATIONS

Requesting Authorizations

ValueOptions of Kansas providers are to submit authorizations using the Kansas Client Placement Criteria (KCPC) system which is based on the medical necessity criteria identified by American Society of Addiction Medicine (ASAM). KCPC refers to the standardized, computer-based assessment tool which gathers biopsychosocial information for a Member utilizing criteria established by ASAM for determining the level of treatment a Members needs. Value Options staff reviews an authorization submitted via the KCPC and makes a medical necessity decision and returns an approval or denial. Providers will continue to submit the minimum data set on the KCPC (as designated by the blue diamonds) on all members for the purpose of collecting data maintained on the SRS Health Care Policy Member information system. This minimum data set does not include member identifying information and provides critical information for state planning and advocacy.

NOTE: Authorization of services is not a guarantee of payment. Payment depends on a number of factors including member eligibility or provider contract status.

Pre-certification

Pre-certification is required for all services; however, ValueOptions shall permit Members to self-refer (i.e. access services without prior authorization) under the following circumstances for Covered Services: Members shall be able to access all outpatient services without a referral up to a pre-specified initial authorization limit when the KCPC is completed and submitted by the provider. In addition, social detoxification services, and any service for any woman who is pregnant or has dependent children, can be accessed without a referral up to a pre-specified initial authorization service limit when the KCPC is completed and submitted by the provider. For services above that limit, Members shall obtain prior authorization.

Clinical Department Hours of Operation

Licensed clinicians are available 24-hours a day, 7 days a week, and 365 days a year including nights, weekends, and holidays. It is imperative that in the event of emergent care, providers contact ValueOptions as soon as possible, but no later than 24-hours after the emergent contact/session/admission.

Authorization Process

Providers are encouraged to start with the ValueOptions system “Provider Connect” to verify a member’s enrollment and eligibility.

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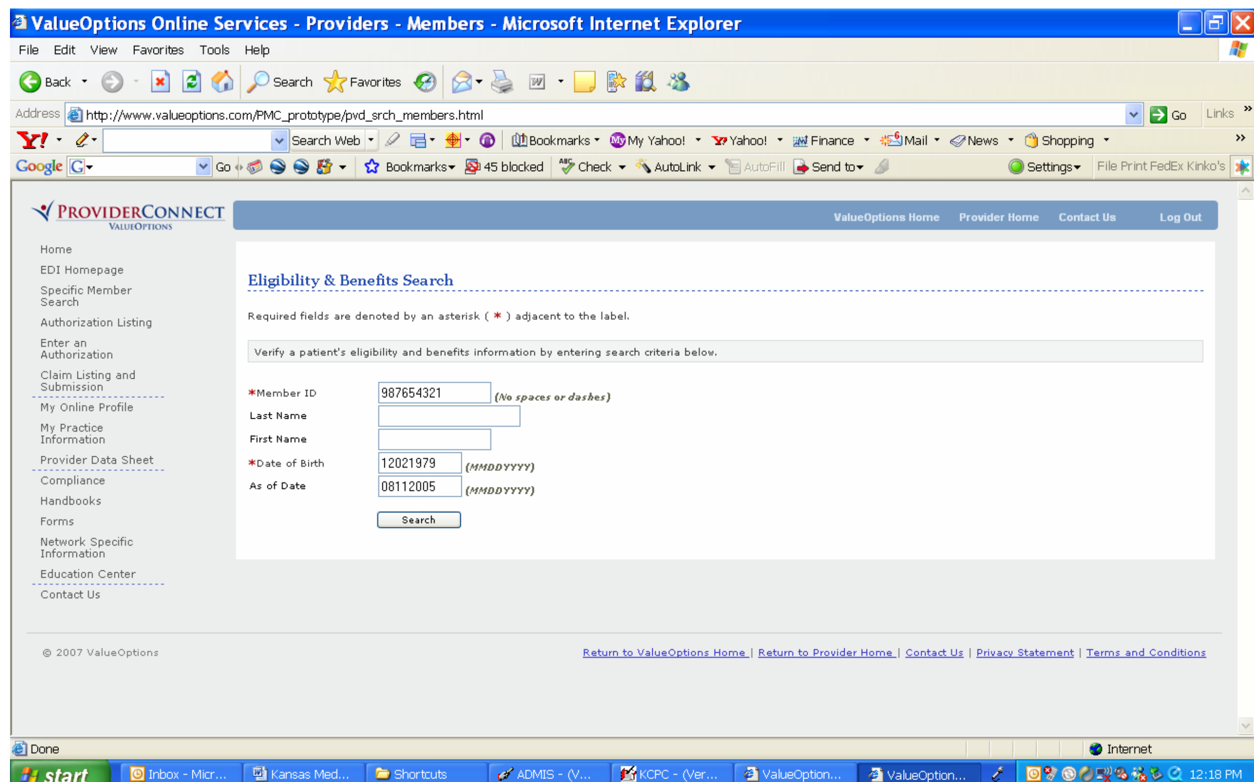
The member look-up screen requires the following elements:

Member ID (Medicaid number or "Unique ID+ (last 4 digits of the social security number)" in KCPC for AAPS funded members). If the member has a Medicaid number, you should look up the member under their Medicaid ID and if they are not there you should look them up under their unique KCPC ID with the last 4 digits of the SSN added to the UniqueID.
Last Name
First Name
Date of Birth
As of Date



Once the member's eligibility has been established, the provider or RADAC should proceed with the assessment or CSR to request the needed service. If the member search show the member is enrolled but not eligible, then the provider should call the ValueOptions Kansas Access line for further information on accessing service authorization. This step is created to eliminate the risk of duplicate KCPC assessment when a member has an open file at another provider.

KCPC Assessment and Request for Services

There must be a completed assessment in place to request services. If an assessment has been completed by another agency or RADAC then the file can be obtained from ValueOptions with the submission of a member signed release of information sent to ValueOptions. Only a member can sign the release of information. This process for release of information applies for Transfers from

Level (TFL), and Open Continued stay reviews (OCSR). The assessment must cover all six dimensions of the KCPC and the criteria summary page. The KCPC help section is an excellent guide for assistance on completing the KCPC.

Requesting Services

When requesting authorization for services you must first have a completed assessment which allows access to the service request/authorization screen in the KCPC. In the summary notes section of the KCPC request for services, you should enter any and all information you believe was not captured elsewhere in the KCPC. Additionally you should indicate if this is request is for another provider or a transfer from level. From the Request for Services / Authorization screen complete the following steps:

1. Choose the modality.
2. Enter the Service Period Start Date.
3. The Service Period Start Date must be on or after the screening date, except for Social Detox (which can be up to 48 hours prior to the screening date).
4. The Service Period End Date and Continued Stay Review Date will be defaulted based on the level of care. The Continued stay review date may be changed if necessary.
5. A primary counselor may be chosen from the Primary Counselor drop down list. If the desired counselors name is not in the list, you will need to close the service request form, add the counselor in the Primary Counselor Screen, then go back into the service request. The primary counselor chosen may be used when billing modalities in the Treatment Billing System.
6. Providers should enter the number of units requested (ValueOptions will authorize). Non-funded member service requests are automatically authorized.
7. Only Providers can access the provider notes section, and only ValueOptions can access the VO notes section.
8. Click *Save* to save the entry.
9. If the member is going to be in more than one type of care at the same time, they should be added here. Click the *Add* button to get a fresh screen, and click *Save* when done.
10. A funded member service request can be edited until it is authorized by the VALUEOPTIONS. The screen will be locked after authorization.
11. If a mistake is made, VALUEOPTIONS may make changes after authorization.
12. When all services for the service period have been completed, choose *Return*. The file will be "Marked to Send" automatically.

ValueOptions will review the service request when submitted and based on the criteria make a determination or notify the provider if the services can not be authorized. The provider will be notified through the KCPC and will be able to track the information on the authorization in Provider Connect.

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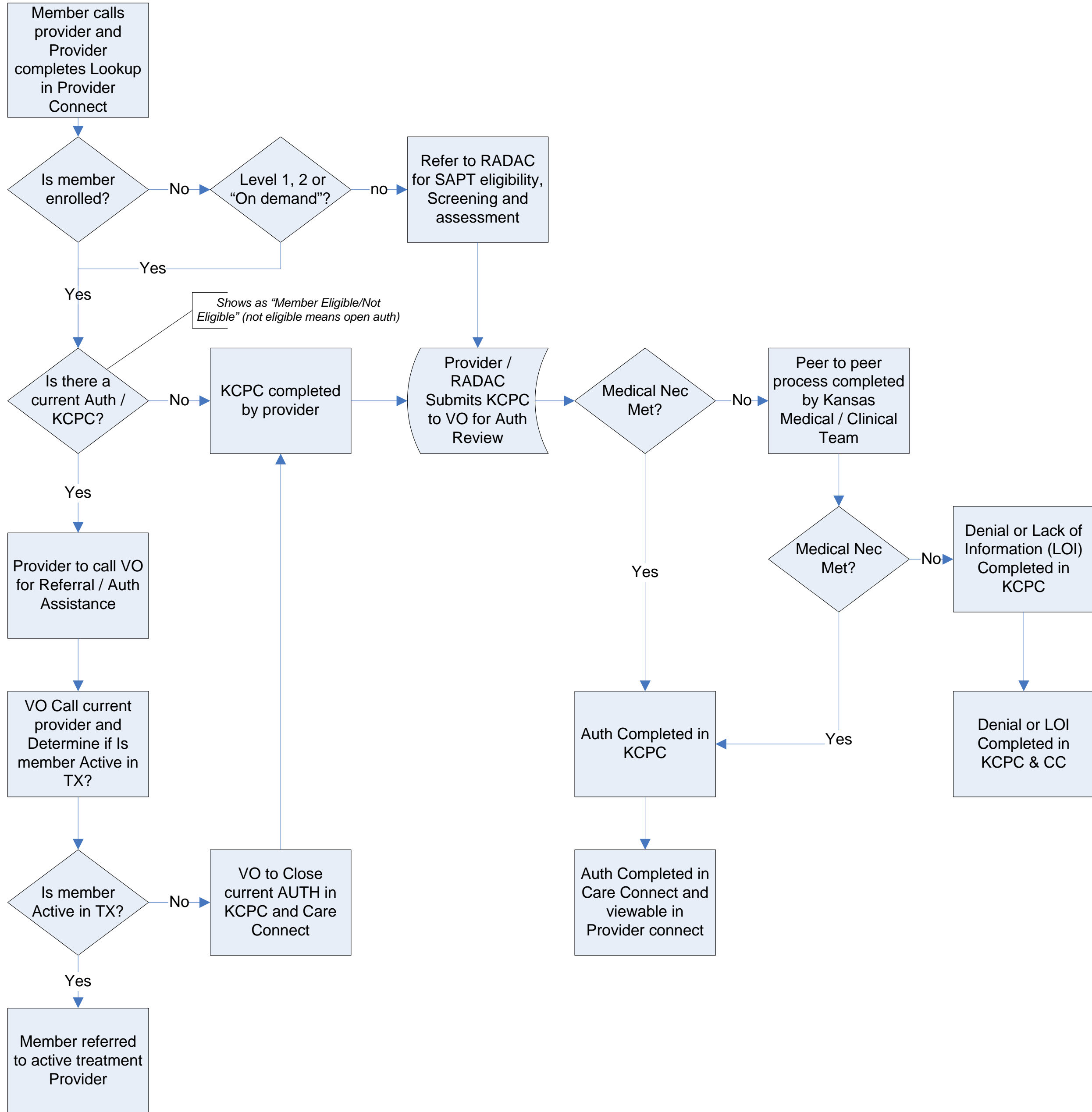

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KCPC Movement of Member files between Licensed Treatment providers including Discharge/ Transfer from Level and Continued stay reviews

There is a difference between a discharge from Your Agency and a discharge from the KCPC system. You can discharge a member from Your Agency and leave the KCPC open so that the member can access treatment services at another provider in Kansas. This is not called a discharge in the KCPC system, regardless of whether you consider the member discharged from your facility.

To leave the KCPC treatment episode open and active for referral to a different provider there are two options:

1. Transfer from Level to New Provider (TFLtoNP)
This is only to be used if you are referring the member to a different substance abuse provider at a DIFFERENT Level of Care (i.e. moving from Level 1 at Your Agency to L2IOP, L3I, L3R or L3SD at a new provider).

2. Continued Stay Review to New Provider (Often called an Open CSR to NP or OCSRtoNP).
This is to be used only if you are referring the member to a different substance abuse provider at the SAME Level of Care (i.e. Level 1 to Level 1).

These options are not interchangeable. The TFL is to be used only when the Level of Treatment is being changed while the OCSR is to be used only when the Level of Treatment is remaining the same.

You can leave an OCSRtoNP open on the KCPC system if you are recommending that the member access substance abuse treatment on his/her own or with the help of a case worker or care manager after they reach their next residential placement. This does not mean community self help groups like AA, NA etc.; it is only used if you are recommending treatment at a licensed treatment provider.

If you know where the member is going after Your Agency, your counselors need to facilitate coordination of care and referral between your agency and the next. The information regarding who the next provider will be needs to be included in the tx recommendations on the TFLtoNP or the OCSRtoNP. When this is received on the ValueOptions worklist in the KCPC system, it will be reviewed and will be approved or denied based on the clinical evidence presented. When it is approved, ValueOptions will send Approval to the next treatment provider per your documentation.

Once the TFL or the OCSR are approved by ValueOptions, the episode will become inactive on your local system. If it is denied, you will be asked in the return documentation to enter the corrected activity that is necessary to move the file.

If a member episode is left open in the centralized statewide database through the use of an OCSRtoNP or a TFLtoNP and the member does not access further tx, the episode file will be automatically discharged after a set amount of time.

Medical Necessity and Adverse Determinations

If the clinical information does not substantiate the request for services then, upon review by a physician the care will not be certified and the provider will be notified through the KCPC and by mail. The member will also receive a letter informing them that the care was not authorized.

Following a service denial the member may request an appeal directly or through their provider acting as an agent for the member. For the guide on seeking an appeal of a service denial, please see the section titled *Member Rights and Protections* on page 38. This will provide the complete description of the Appeal Policy and Procedure.

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VALUEOPTIONS KANSAS

■ ■ ■ CLAIMS

PLEASE NOTE THAT THERE IS A SEPARATE INSTRUCTIONAL MANUAL FOR BILLING INFORMATION

Claims and Block Grant Reimbursement Request Billing Information

When submitting Block Grant Reimbursement Requests please follow the same procedures that should be used when submitting regular Fee for Service Claims. Please note that unless identified specifically, the terms "Claims" and "Block Grant Reimbursement" are used interchangeably.

Claims and Block Grant Submission Requirements

A clean claim is a UB-04 or CMS-1500, submitted by a provider for medical care or health care services rendered to a covered Member which accurately contains information including, but not limited to:

- Member's name and date of birth
- Covered Member's identification number
- Date(s) and place of service or purchase
- Services and supplies provided
- ICD-9 code
- CPT-4 code (CMS 1500 form)
- Revenue Code for UB-04 (CMS1450) form (primarily for hospital-based services)
- Provider's name, address and tax identification number
- Provider's National Provider Identifier (NPI)
- Taxonomy Code (on claims submitted electronically)
- Provider's license number
- Provider's charges
- Other information or attachments that may be mutually agreed upon by the parties in writing

In addition, the claims must be free from defect or impropriety (including lack of required substantiating documentation) or circumstance requiring special treatment that prevents timely payment. If additional information is required, the provider agrees to cooperate by providing any information reasonably requested for the purpose of consideration and in obtaining necessary

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information relating to coordination of benefits, subrogation, and verification of coverage and health status. All billings by the provider will be considered final unless adjustments or an appeal request is received by ValueOptions within 60 calendar days from the date indicated on the Explanation of Benefits form sent by ValueOptions on behalf of payer. Reimbursement is based upon certification for services covered under the Member's benefit plan and the Member's eligibility at the time of service.

Timely and accurate processing of claims is important to ValueOptions. Following the instructions below will facilitate efficient processing of your claim within acceptable timeframes.

- Clean claims must be submitted on one of the two national industry standard billing forms, both of which have been updated this year and include new fields for the National Provider Identifier and Taxonomy codes.
  - **Definitions: NPI – National Provider Identifier** – is the single provider identifier, replacing the different provider identifiers currently used for each health plan with which you do business. This identifier, which implements a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), must be used by most HIPAA covered entities, which are health plans, health care clearinghouses, and health care providers that conduct electronic business for which the Secretary had adopted a standard (i.e. standard transactions).
  - **Taxonomy Code –** The Health Care Provider Taxonomy code set is a collection of unique alphanumeric codes, ten characters in length. The code set is structured into three distinct "levels" including Provider Type, Classification, and Area of Specialization. The Health Care Provider Taxonomy code set allows a single provider (individual, group, or institution) to identify their specialty category. Providers may have one or more than one value associated to them. A list of the valid Taxonomy codes begins on Page 38 of this document.

  - Center for Medicare and Medicaid Services/CMS-1500 (formally known as HCFA-1500); or
  - Uniform Billing Form/UB04 (CMS-1450) or HCFA-1450.

- Completed claims forms may be mailed to:

ValueOptions
P. O. Box 12698
Norfolk, VA 23502
ATTN: KS Claims

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1. **Time Limit for Filing Claims and Block Grant Reimbursement Requests**

   a. **Claims -** Initial claims for covered services must be submitted within ninety (90) days of the date of service to be considered for reimbursement. Initial claims submitted beyond the ninety (90) day time limit may be zero paid/initially denied (for timely filing) on the ValueOptions provider summary voucher (Explanation of Benefits, EOB).

   b. **Block Grants –** Initial claims/requests for block grant reimbursement must be submitted within ten (10) days of the date of service to be considered for reimbursement. Initial block grant requests submitted beyond the ten (10) day time limit may be zero paid/initially denied (for timely filing) on the ValueOptions provider summary voucher (Explanation of Benefits, EOB). NOTE: If the claim is received within the same month as the service was rendered the 10-day timely filing limitation will be waived. All requests for block grant reimbursements must be received by the 10th of the month following the date of service.

   c. **Claims Involving Third Party Liability (TPL)** must be submitted within ninety (90) days of the date of the other carrier's Explanation of Benefits (EOB), or notification of payment / denial. Initial claims involving TPL that are submitted beyond ninety (90) days from the date of service may be zero paid/initially denied (for timely filing) on the ValueOptions provider summary voucher.

2. **Incomplete Claims or Block Grant Reimbursement Requests**

   a. Claims may be "zero-paid/initially denied" by ValueOptions in the case of incorrect or incomplete required data elements.

   b. ValueOptions may notify the provider, via the provider summary voucher (EOB), of those data elements requiring completion or correction. The required data elements and other claim submission requirements are outlined in Sections C1 and C2 of this manual.

3. A separate claim form must be submitted for each rendering provider of service.

4. **In order to submit claims for Block Grant reimbursement, the provider must have a specific contract with ValueOptions for the Block Grant services.**

5. The service location must be submitted on all claims. ValueOptions will use this address information in conjunction with the NPI to select the appropriate provider record for processing the claim on our system.

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6. **Itemized bills are required.** All pertinent information is necessary to process a claim promptly and accurately. Please make sure to include the following elements when submitting a claim:

   - Dates of service should be listed individually on CMS-1500 claim forms (NO DATE SPANS).
   - Valid ICD-9 diagnosis codes (NOTE: ICD-9 diagnosis codes are required for electronically submitted claims).
   - Rendering provider and provider billing information, including tax identification number entered in appropriate areas of UB04 and CMS 1500 forms.
   - Appropriate and valid place of service codes with correlating appropriate and valid CPT codes (and Revenue codes, when billing on a UB04 (CMS-1450).
   - Accurate Member/Member information including Member identification number, Member name and Date of Birth. Please do not use nicknames.

7. **Authorization and claim must match:** The services billed must correspond to the care that was authorized. In order for payment to occur, the procedure/revenue code and dates of service must match those authorized.

8. **Claims Payment –** For paper claims received the use of scanning by means of Optical Character Recognition (OCR) technology allows for a more automated process of capturing information. This technology enables ValueOptions to shorten turnaround time and improve quality. The following elements are required to take advantage of this automated process. If you do not follow the guidelines, your claim will still be processed, however, it will require manual intervention and may take longer to process.

- Use machine print
- Use original red claim forms
- Use black ink
- Print claim data within the defined boxes on the claim form
- Use all capital letters
- Use a laser printer for best results
- Use white out or correction tape for corrections
- Submit any notes on 8 1/2" x 11" paper
- Use an eight-digit date format (e.g., 10212006)
- Use a fixed width font (Courier, for example)

VALUEOPTIONS KANSAS

Claims and Block Grant Submission Policy

1. ValueOptions will process claims for dates of service on or after July 1, 2007.

2. If claims are not being submitted electronically, original paper claims for covered services must be submitted directly to:

   ValueOptions
   P. O. Box 12698
   Norfolk, VA 23502
   ATTN: KS Claims

   Please note; copies of claims and faxed claims will not be accepted as an Initial Claim.

3. Detailed instructions on required data elements for completing the claim forms are outlined in sections C1 and C2, below.

4. ValueOptions accepts claims submitted electronically; please see Section D.

5. Please refer to your provider agreement for the covered services that you have been contracted for, and the definition of services included in the reimbursement rates.

6. Medicaid Claims should be submitted with the Member's Medicaid ID Number; failure to use this permanent ID number may result in the denial the claim on the provider summary voucher (EOB).

7. Block Grant claims should be submitted with the Member ID Number issued in the KCPC.

8. Claims must be submitted with valid and complete ICD9 diagnosis codes. Claims submitted with any other diagnosis code may be zero paid/initially denied on the ValueOptions provider summary voucher (EOB).

9. Before any payments can be made to any provider or facility, the minimum of a completed W9 Form must be on file with ValueOptions.

Electronic Media Claim Submission (EDI and Single Claim Submission)

New Transaction and Code Requirements

Under the Health Insurance Portability and Accountability Act (HIPAA), all covered entities must switch to the new transaction and code standards effective October 16, 2003. Technical instructions, Implementation and Companion Guides for these electronic transactions can be found on the ValueOptions Web site at www.valueoptions.com. In using this system, ValueOptions and providers must:

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(i) Not change any definition, data condition or use of a data element or segment as proscribed in the Health and Human Services (HHS) Transaction Standard Regulation. (45 CFR 162.915(a)).

(ii) Not add any data elements or segments to the maximum defined data set as defined in the HHS Transaction Standard Regulation. (45 CFR 162.915 (b)).

(iii) Not use any code or data elements that are either marked "not used" in the HHS Transaction Standard's implementation specifications or are not in the HHS Transaction Standard's implementation specifications. (45 CFR 162.915 (c)).

(iv) Not change the meaning or intent of any of the HHS Transaction Standard's implementation specifications. (45 CFR 162.915 (d)).

Please contact the EDI Help Desk at 1-888-247-9311 for assistance with becoming a ValueOptions *EDI claim submitter or Single Claim Submitter.*

The **Single Claim Submission** feature is a web-based method of submitting one (CMS-1500) claim at a time to ValueOptions. This method of submitting claims is recommended for a small provider office that would submit no more than 20 claims at a time.

EDI Claims Link for Windows is an electronic claim submission process developed by ValueOptions and is free to providers who wish to submit electronic claims to ValueOptions.

ValueOptions will accept the following HIPAA compliant claim files:

- Files programmed by the Provider's IT Department;
- Files submitted using ValueOptions' EDI Claims Link for Windows software;
- Claims submitted using ValueOptions' Single Claim Submission process. **Note**: **Please see the ValueOptions Provider Guide to using Single Claim Submission, available on the www.valueoptions.com website, under "Providers"**

The following information is required from the provider prior to submitting claims electronically:

- Completed Account Request Form
- Intermediary Authorization Form (if using a billing agent or clearinghouse)
- Files must be HIPAA compliant (if using EDI Claims Link for Windows software, this software is HIPAA compliant)
- Must submit a test file to verify accurate information is included in the file

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MEMBER RIGHTS AND PROTECTION

Members are Not Held Liable

Members are not to be held liable for the following situations:

a. Non-payment— ValueOptions of Kansas shall provide that its Members are not held liable for the covered services provided to the Member, for which the Contracting Agencies does not pay ValueOptions of Kansas, except as allowed for non-T-XIX sliding fee scale payments by Members.

b. Non-payment to provider— ValueOptions of Kansas shall provide that its Members are not held liable for the covered services provided to the Members, for which the Contracting Agencies or ValueOptions of Kansas does not pay the provider that furnishes the services under a contractual, referral, or other arrangement, except as allowed for non-T-XIX sliding fee scale payments by Members

c. ValueOptions of Kansas shall provide that its Members are not held liable

   i. for payments, including ValueOptions of Kansas' debts, in the event of ValueOptions of Kansas' insolvency.

   ii. for payments for covered services furnished under a contractual, referral, or other arrangement, to the extent that those payments are in excess of the amount the Member would owe if ValueOptions of Kansas provided the service directly (i.e. no balance billing by providers.)

SA-PIHP Grievance and Appeals System Requirements

ValueOptions of Kansas has established a grievance system including written policies and procedures that meet the following requirements:

a. provides Members reasonable assistance in completing forms and other procedural steps, not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability;

b. acknowledges receipt of each grievance and appeal;

c. ensures that decision makers on grievances and appeals were not involved in previous levels of review or decision-making and are health care professionals with clinical expertise in treating the Member's condition or disease if any of the following apply:

   i. an appeal of a denial based on lack of medical necessity;

   ii. a grievance regarding denial of expedited resolution of an appeal;

   iii. any grievance or appeal involving clinical issues;

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d. provides the following grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time they enter into a subcontract:

   i. the Member's right to a State Fair Hearing, how to obtain a hearing, and right to representation at a hearing;

   ii. the Member's right to file grievances and appeals and their requirements and timeframes for filing;

   iii. the availability of assistance in filing;

   iv. the toll-free numbers to file oral grievances and appeals;

   v. the Member's right to request continuation of benefits (as defined in 42 C.F.R. § 438.420(b)(1)) during an appeal or State Fair Hearing; if ValueOptions of Kansas' Action in a State Fair Hearing is upheld, the Member may be liable for the cost of any continued benefits;

   vi. any State-determined provider appeal rights to challenge the failure of the organization to cover a service.

SA-PIHP Grievance Process

Procedure:

A. Receipt of Grievance

1. The Grievance Coordinator receives the grievance orally or in writing. Upon receipt of the grievance and verification that the grievance was filed timely the issue is entered into the VO-KS database. VO-KS makes available reasonable assistance for the member with completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
2. The Grievance Coordinator logs the grievance in the database documenting the date received, name of the grievant and nature of the grievance.
3. The Grievance Coordinator acknowledges all written or verbal grievances with an acknowledgement letter within five (5) business days of receipt. The acknowledgement letter includes the VO-KS address and phone number and the expected date of resolution.
4. The Grievance Coordinator works toward resolution with other VO-KS staff as necessary, such as:
   a. Provider Relations
   b. Claims Department
   c. Clinical Operations Department
   d. Regional Offices

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5. If a potential Quality of Care issue is identified, the case is forwarded to the Director of Quality Management, or designee, for oversight and investigation.
6. If a resolution cannot be completed within 14 calendar days, the grievant is contacted either telephonically or in writing prior to the 14th day and is advised of the status of the grievance.
    a. The resolution timeframe may be extended up to 14 calendar days if the member requests the extension or if VO-KS demonstrates that there is need for additional information and the extension is in the member's interest.
    b. For any extension not requested by the member, VO-KS shall give the member written notice of the reason for the extension within 2 working days of the decision to extend the timeframe.
7. The written resolution response to the member contains all required information including but not limited to:
    a. All information considered in the investigation of the grievance;
    b. Findings and conclusions based on the investigation; and
    c. The disposition of the grievance.
8. The Grievance Coordinator updates the grievance database to include the resolution date of the grievance and the disposition.

B. Reporting, Tracking, and Trending
1. The Director of Quality Management, or designee, is responsible for ensuring the timely resolution of grievances through regular review of the tracking database.
2. Grievances are tracked according to the following categories:
    a. Access to Care/Services
    b. Clinical Issues
    c. Care Disruption Issues/Terminations of Care
    d. Claims/Invoice Issues
    e. Formulary Issues
    f. Quality Issues
    g. Utilization Review Issues
    h. Other categories as needed
3. The Director of Quality Management, or designee, reviews all grievances on a monthly basis to identify patterns.
    a. Action plans are developed as issues are identified.
    b. Patterns of poor quality are forwarded to the VO-KS Clinical Quality Committee as necessary.

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4. The Grievance Coordinator provides the VO-KS Clinical Quality Committee with monthly summary reports for review and recommendation.
5. The Director of Quality Management submits grievance reports to the SRS, as required by contract.

C. All documentation related to the grievance is maintained through the grievance file in accordance with confidentiality requirements.

1. VO-KS documents the following information, (but not limited to):
   a. Date of filing of grievance;
   b. Name, identifier, and nature of the grievance;
   c. Date of the acknowledgment letter;
   d. Dates of decision to extend the timeframe as well as SRS approval and member notification;
   e. The determination made including the date of the resolution, the title(s) of the personnel and credentials of any clinical personnel who participated in each determination;
   f. Date the resolution letter is mailed to the grievant;
   g. All correspondence between VO-KS and the grievant, including notices of final resolution and all other pertinent information.
2. The grievance file is released to the member (or their representative) upon request as permitted by federal and state confidentiality laws and regulations.

SA-PIHP Appeals Process

Appeal Policy

Members or their designated representatives have the right to initiate the appeal of any adverse medical necessity determination up to 30 thirty calendar days from the date on the Notice of Action letter. A provider or facility, acting on behalf of the member as confirmed in writing, may file an appeal of any adverse medical necessity determination. Appeal requests can be made orally or in writing; however, an oral request to appeal shall be followed up by a written, signed, appeal.

As part of the appeals process, a member, designated representative, provider, or facility rendering service can submit written comments, documents, records, and other information relating to the case. ValueOptions takes all such submitted information into account in considering the appeal regardless of whether such information was submitted or considered in the initial consideration of the case.

Appeals considerations are conducted by health professionals (Peer Advisors) who:

1. Are clinical peers;
2. hold a current active, unrestricted license to practice medicine or a health profession;
3. if medical doctors, are board-certified;
4. are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate; and
5. are neither the individual who made the original non-certification, nor the subordinate of such individual.

Members may file a State Fair Hearing at any stage of the appeal process up to 30 calendar days from the Notice of Action. Kansas does not require Members to exhaust the ValueOptions appeals process before Members may requests a State Fair Hearing. Appeals records are maintained for at least ten years.

Appeal Definitions:

A. **Standard Appeal -** The first review of a medical necessity adverse determination conducted at the request of a member, designated representative, or the Provider of Record by a ValueOptions' Peer Advisor (PA) who is neither the individual who made the original non-certification decision nor the subordinate of such an individual for the purpose of determining medical necessity for authorization.

B. **Initiation of Appeal Process –** A valid appeal is initiated when:

   1. The member, provider, facility rendering service, or the member's designated representative has requested the appeal with written confirmation if not a request for expedited appeal.
   2. The request includes at least the member's name or identification number and the dates of service for which a denial of services or claims payment for services is the subject of the appeal request; and
   3. The request is received within 30 calendar days of the date on the Notice of Action.

D. **Clinical Peer -** A physician or other health professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the ordering provider.

E. **Expedited Appeal -** An expedited appeal is a request to review a decision concerning admission, continued stay, or other behavioral healthcare services for a member who has received urgent services but has not been discharged from a facility, or when a delay in decision-making might seriously jeopardize a Member's life, health, or ability to attain, maintain, or regain maximum function.

F. **Provider of Record** – The physician or other health care provider that has primary responsibility for the care, treatment, and services rendered to the member *or* the health care facility where treatment is requested on an inpatient or outpatient basis.

G. **Retrospective Appeal** - A review of relevant medical record documentation by a ValueOptions' Peer Advisor who is neither the individual who made the original noncertification decision nor the subordinate of such an individual, after a member has been discharged from the level of care or service under review.

Appeal Procedure:

A. Initiation of Appeal Process

1. Providers and members are informed verbally and in writing about their rights of appeal and the appeal process, both standard and expedited, after an adverse determination is made.
2. Providers, facilities, members or designated representatives, may request a clinical appeal either verbally or in writing up to 30 calendar days after receipt of notification of a clinical non-certification. Oral requests to appeal shall be followed by a written, signed, appeal. An appeal by the Provider on behalf of the Member must be confirmed in writing by Member.
3. When ValueOptions receives a timely appeal request, the appropriate staff person verifies the type of appeal requested by referencing the clinical record and opens an appeal record, which is maintained either in electronic or paper-based format. The appeal record includes at a minimum:
    a. The name of the requestor;
    b. Date of request;
    c. Names of member, provider and facility rendering services;
    d. Copies of all correspondence between the member, provider, or facility rendering service, and ValueOptions regarding the appeal;
    e. Dates of appeal reviews, documentation of actions taken, and final resolution;
    f. Minutes or transcripts of appeal proceedings (if any).
4. Within five working days of receipt of the appeal, the date of appeal request is acknowledged in writing, and the requestor is informed of what information, if any, is required to conduct the appeal, and timeframes for submission. In addition, the requestor is informed that the member, provider, or facility rendering service can submit any written comments, documents, records, and other information relating to the case. Before and during the appeal process, the Member and/or the Member's representative may request to review the Member's case file, including clinical records, and any other documents. ValueOptions shall also provide a reasonable opportunity for allegations of fact or law to be presented in person as well as in writing.

5. When a request for an appeal of adverse determination is received orally, a one-page appeal form is sent to the appealing party at the time receipt of the appeal is acknowledged.
6. When an appeal is requested, but requested information is not received within the decision timeframe, the appeal is conducted based on whatever information is available and a decision is rendered within appropriate timeframes.
7. When the appeal process has been initiated within time standards, the Medical Director or designee assigns the case to an appropriate Peer Advisor or to the appropriate external review body as indicated to conduct the review based on the type of appeal.

B. Standard Appeal

1. Upon being assigned a case for appeal review, a ValueOptions Peer Advisor undertakes a full investigation of the substance of the appeal, including aspects of the clinical care involved. The Peer Advisor considers all documents, records, or other information submitted by the member, provider, or facility rendering care (regardless of whether such information was submitted or considered in the initial consideration of the case), and the clinical criteria and treatment guidelines used by ValueOptions. The Peer Advisor processes the appeal request as required (i.e. peer to peer conversation, or clinical peer review of the submitted documentation).
2. Based on consideration of all pertinent information, including relevant criteria and guidelines, the Peer Advisor makes a determination to reverse (i.e., overturn) the original adverse determination in whole or part, or to uphold the original adverse determination.
3. When the appeal review is completed, the Peer Advisor or designee verbally informs the provider of the decision including the length of authorization and the level of care authorized, and/or any alternatives/ recommendations, which are clinically appropriate. The Member's UM record is updated to reflect the substance of the appeal and the actions taken.
4. The Clinical Appeal is completed as expeditiously as the Member's health condition requires but no later than the14 calendar days from the date appeal request was received.
5. Written notification of the appeals decision is sent within the determination timeframe for all Standard and Expedited Appeals.
6. Members may request an extension of 14 days for standard appeals if they need more time to submit information.
7. ValueOptions may request an extension of 14 days to complete a standard appeal resolution. The need for additional information and extension of time must be justified, show how the delay is in the Member's interest, and requires the approval of Kansas Social and Rehabilitation Services (SRS).

C. Expedited Appeal

1. An expedited appeal may be requested when the provider indicates, or ValueOptions determines, that following the standard appeal time frame could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.
2. The Member or provider may file an expedited appeal either orally or in writing. No additional Member follow-up is required.
3. ValueOptions will inform the Member verbally of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing, in the case of an expedited resolution.
4. The expedited appeal will be completed and notice provided as expeditiously as required by the Member's condition, but, no later than 3 business days after the appeal is received.
5. Members may request an extension of 14 days for standard appeals if they need more time to submit information.
6. ValueOptions may extend the timeframes by up to 14 calendar days, with approval by SRS. ValueOptions must show that there is need for additional information and show how the delay is in the Member's interest. ValueOptions will notify the Member of the reason for the extension.
7. If ValueOptions denies a request for expedited resolution of an appeal, efforts will be made to provide Member with prompt oral notice and written notice will follow within 2 calendar days. Furthermore, the appeal will be transferred to the standard appeal timeframe. Member may file a grievance in response to this decision.

D. Retrospective Appeal

1. When a member is discharged from the service or level of care under consideration prior to an initiation of the appeal process, the treating provider and/or the member has the right to request a Retrospective Appeal.
2. The member, provider of record or the facility rendering services is informed of the relevant medical record documentation needed to conduct the appeal review and the timeframe within which the documentation must be received.
3. A ValueOptions' Peer Advisor reviews the record to determine medical necessity of the services or days that were not certified as a result of the Peer Review decision. Such retrospective review shall be based on written screening criteria established and periodically updated with appropriate involvement from physicians, including practicing physicians, and other health care providers.
4. This review is completed within 14 calendar days of the initiation of the appeals process. Written notification is issued to attending or ordering provider, facility and patient within the 14 calendar days determination timeframe.

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5. The same 14 day extension requests as presented in the Standard appeal process may be applied in the Retrospective Appeal process.

For all types of appeals, Peer Advisors document their decision in the UM record, legibly if in hard copy, and according to Service Center standards, which include at a minimum:

a. Timeliness information and data source of review
b. Clinical criteria supporting the decision
c. Clinical rationale to support the decision
d. Identification of contact and time
e. Determination and reason for the determination
f. Name and credentials of the clinical peer

E. Fair Hearing – ValueOptions notifies members of their rights to a State Fair Hearing at the time the Notice of Action is given, as well as, at the time of decision for Standard or Expedited Appeals. ValueOptions provides assistance to the member or the member's representative in accessing the fair hearing process, to the extent necessary.

1. Members may file a request for a State Fair Hearing at any stage of the appeal process and are not required to exhaust the ValueOptions' appeal process first.
2. The State Fair Hearing can be requested up to 30 calendar days from the date of the Notice of Action. Furthermore, a Member may seek a State Fair Hearing if not satisfied with ValueOptions' decision in response to an appeal.
3. A State Fair Hearing request must be made in writing, signed, and sent to the **Office of Administrative Hearings, 1020 S Kansas Avenue, Topeka, KS 66612-1311**. Fair Hearing Request forms can be accessed at http://www.da.ks.gov/hearings/request.htm.

F. Continuation of Benefits

1. Services to the Member will be extended during an appeal if all of the following criteria are met:
   a. the appeal is filed on or before the later of:
      i. ten calendar days of the Notice of Action
      ii. the intended effective date proposed in the Notice of Action
   b. the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
   c. the services were ordered by an authorized provider
   d. the authorization period has not expired

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e. The Member requests continuation of benefits.

2. The benefits shall be continued until one of the following occurs:
   a. Member withdraws the appeal
   b. Ten calendar days have passed since the date of the appeal resolution letter when the initial adverse decision is upheld (unless the member requested a Fair Hearing with continuation of benefits)
   c. State Fair Hearing decision is issued that is adverse to the Member
   d. authorization expires or authorization service limits are met
3. ValueOptions may recover the cost of the continuation of services furnished to the Member while the appeal was pending if the final resolution of the appeal upholds the adverse determination.

G. Notifications

1. ValueOptions shall provide written notice of resolution for standard and expedited appeals within the decision timeframe.
2. Written resolution notice shall include:
   a. the results and date of the appeal resolution;
   b. for decision not wholly in the Member's favor:
      i. the right to request a State Fair Hearing
      ii how to request a State Fair Hearing
      iii. the right to continue to receive benefits pending a hearing;
      iv. how to request the continuation of benefits; and
      v. notice that Member may be liable for costs of any continued benefits if the action of ValueOptions is upheld in hearing.
   c. that in the State Fair Hearing the Member may represent him/herself or use legal counsel, a relative, a friend, or a spokesperson;
   d. the specific regulations that support, or the change in federal or State law that requires the Action, and
   e. an explanation of the individual's right to request an evidentiary or State Fair Hearing in some cases if the Action is based on change in law

H. Monitoring and Reporting

1. Service Center staff monitors the appeals process to ensure all appeal requests are responded to within contractual guidelines and that all applicable appeal rights are made known to the appropriate individuals.

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2. Compliance with appeals decision and notification policy and procedures is tracked and reported monthly to the Service Center Quality Management Committee and to the Corporate Quality Council on a quarterly basis.
3. Service Center staff maintains a monthly log of all appeals, including State Fair Hearings The log minimally includes:
    a. The VO-KS ID number for the member,
    b. The Level of Care originally denied,
    c. The provider
    d. The date the appeal was received,
    e. The type of appeal requested,
    f. The date the appeal was completed,
    g. The outcome of the appeal, and
    h. The number of days required to complete the appeal
4. ValueOptions submits appeals reports to Kansas Social and Rehabilitation Services summarizing each appeal handled during the quarter.

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■ ■ ■ QUALITY MANAGEMENT

Role of Participating Providers

ValueOptions′ providers are informed about the Quality Management Program via the ValueOptions' Provider Handbook, provider newsletters, Web site information, direct mailings, seminars and training programs. Many of these venues provide network providers with the opportunity to provide input into the QM Program. Opportunities for provider participation and input into the QM Program also include representation on a number of National and VO-KS service center level committees (for details on committee participation contact the ValueOptions Topeka Service Center at 1-866-645-8216.) Through these venues, participating providers:

- Provide input into the ValueOptions' Clinical Criteria;
- Provide peer review and feedback on proposed practice guidelines, clinical quality monitors and indicators, new technology and any critical issues regarding policies and procedures of ValueOptions;
- Review QI activities and make recommendations for improvement plans to improve quality of clinical care and service;
- Review, evaluate and make recommendations for the credentialing and recredentialing of network providers; and
- Review, evaluate and make recommendations regarding sanctions that result from provider performance issues.

Scope of the ValueOptions' Quality Management Program

The VO-KS Quality Management Program monitors and evaluates quality across the entire range of services. The program is intended to ensure that the structure and processes in place lead to desired outcomes for both members and providers.

The scope of the QM Program includes:

- Clinical Services/Utilization Management Programs;
- Quality Improvement Activities/Projects;
- Outcome Management;
- Network Management/Provider Relations Activities;
- Satisfaction Surveys;
- Clinical Treatment Record Evaluation;
- Service Availability and Access to Care;

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- Practitioner and Provider Quality Performance;
- Member and Provider Grievances;
- Member Rights and Responsibilities;
- Member Safety Issues;
- Clinical and Administrative Denials and Appeals;
- Quality Indicator development and monitoring; and
- Cultural Competency.

Confidentiality

ValueOptions' employees routinely maintain as confidential all information collected relating to past and present members, including identity, as well as personal information.

Protected Health Information (PHI) is maintained on a confidential basis in accordance with all applicable regulatory requirements. ValueOptions ensures that all such information obtained during the utilization management process is used solely for the purposes of utilization management, quality management, disease management, discharge planning, case management, and claims payment. All ValueOptions' employees are required to sign a statement of confidentiality at the time of employment and every annual evaluation thereafter. All ValueOptions' employees, providers and delegated entities are expected to safeguard the confidentiality of Utilization Management (UM) and Treatment Records information related to both enrolled and disenrolled members. ValueOptions maintains information systems to collect, maintain, and analyze information necessary for utilization management that incorporates adequate safeguards to ensure the confidentiality and security of UM and Treatment Records as well as a plan for secure storage, maintenance, tracking and destruction of member-identifiable clinical information.

All requests for authorizations for disclosure of information are reviewed and responded to in accordance with ValueOptions' policy, as well as all applicable laws and regulations.

Members are entitled to receive copies of any information pertaining to themselves, on request, subject to limits placed by state and federal guidelines, and an evaluation of any potential risk of harm to the member entailed by such disclosure of information.

Confidential information may include but not be limited to:

- Protected Health Information (PHI);
- Certification of mental health treatment;
- Claims processing information;
- Utilization review;
- Peer review;

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- Appeals; and
- Quality assurance

Individuals engaged in quality improvement activities maintain the confidentiality of the information used in such activities. All written reports, records or any work product or communication related to quality improvement activities are considered privileged and confidential information. Except when specific reference is necessary to meet the goals of the QM program, reference to individual providers or members are redacted to safeguard the person's identity.

Periodic re-training efforts reinforce the importance of confidentiality. All members and providers who participate on ValueOptions' committees must also demonstrate their understanding of ValueOptions' confidentiality policies and procedures by signing confidentiality statements prior to committee participation. Participating provider contracts are explicit in regard to treatment record confidentiality requirements.

Quality Improvement Activities/Projects

The primary goal of ValueOptions' QMP is to continuously improve member care and services. Through data collection, measurement and analysis, aspects of care and service that evidence problems can be targeted for corrective action. Data collected for quality improvement projects and activities are related to key indicators of quality that focus on high-volume diagnoses or services and high-risk diagnoses, services, or special populations. Data are statistically valid, reliable and comparable over time.

ValueOptions' Annual Quality Management Workplan

Annually, ValueOptions develops a QM Workplan addressing the quality and safety of clinical care and the quality of service. The QM Workplan includes QM goals and objectives, areas of focus, and identifies specific QM related activities scheduled for the upcoming year. Scheduled activities include target date for completion and responsible party as well as the tracking of previously identified issues and planned evaluation of the QM program.

Annual Evaluation of ValueOptions' Quality Management Plan

The Quality Management Program is reviewed and evaluated annually. The evaluation consists of a comprehensive summary of the accomplishment of objectives, committee activity, quality improvement activities and indicators. The evaluation assesses the effectiveness in improving quality of care and service delivered by the ValueOptions.

GLOSSARY OF TERMS

* *Represents definition from the Centers for Medicare & Medicaid Services*
** *Represents definition from the American Psychiatric Glossary, 1994, American Psychiatric Press, Inc., Washington DC*

Abuse or Inappropriate Billing
Providers agree that in no event, including, but not limited to, nonpayment by ValueOptions or payer, insolvency of ValueOptions or payer or breach of the provider/facility agreement with ValueOptions, shall the provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member, for health care services provided pursuant to this agreement.

American Society of Addiction Medicine (ASAM)
The nation's medical specialty society dedicated to educating physicians and improving the treatment of individuals suffering from alcoholism and other addiction (http://www.asam.org/).

Balance Billing
Providers agree that in no event, including, but not limited to, nonpayment by ValueOptions or payer, insolvency of ValueOptions or payer or breach of the provider/facility agreement with ValueOptions, shall the provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member, for health care services provided pursuant to this agreement.

Contracted Provider
Any hospital, skilled nursing facility, extended care facility, individual, organization or licensed agency that has a contractual arrangement with an insurer for the provision of services under an insurance contract.

Coordination of Benefits (COB)
A provision which requires that when a Member is covered by two or more group health plans, payment will be divided between them so the combined coverage will pay up to 100% of eligible expenses; most group plans contain this provision. The claim is sent to the primary carrier first, and then their explanation of benefits is sent with the claim to the secondary carrier.

Coordination of Care
The process of coordinating care among behavioral health care providers and between behavioral health care providers and physical health care providers with the goal of improving overall quality of a Member's health care.

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Co-payment
That portion of a charge for services that must be paid by a Member and is not covered by the Member's benefit program. Providers are not allowed to bill Members for charges not covered by the Member's benefit plan aside from any applicable copayments and deductibles.

Covered Employee
An employed individual eligible to participate in an employer's health plan or EAP.

Covered Services
Mental health and substance abuse services which are within the scope of the Member's benefit plan.

Deductible
That portion of a charge for a covered service that must be paid by a Member before any insurance coverage applies.

Eligibility
The determination that an individual meets the requirements to receive health care benefits as defined by the employer.

Emergency
A psychiatric emergency exists when an individual with a defined DSM-IV-TR or ICD-9 diagnosis is in significant distress, is significantly dysfunctional and is in real and present danger to him/herself or others. An emergency also exists when there is an immediate and severe medical complication as a consequence of the psychiatric illness or its care. A psychiatric emergency requires immediate direct intervention by a licensed mental health professional who will accept responsibility for emergency evaluation and disposition. A psychiatric emergency does not necessarily require an Inpatient level of care but does require adequate security and medical support to evaluate and treat the psychiatric emergency without risk to the individual or others. (This is a general definition for reference purposes only. Please see your provider contract for the definition appropriate to your contract.)

Fraud
Intentional perversion of truth in order to induce another to part with something of value or to surrender a legal right. An act of deceiving or misrepresenting. Abuse and Inappropriate billing could evolve into fraud.

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Kansas Client Placement Criteria (KCPC) System
KCPC refers to the standardized, computer-based assessment tool which gathers biopsychosocial information for a Member utilizing criteria established by ASAM for determining the level of treatment a Members needs.

Medicaid*
A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Member
Any individual who is covered by the employer's benefit plan. May also be referred to as beneficiary, enrollee, participant (EAP only), or Member.

Mental Health or Substance Abuse Condition or Mental Disorder
A nervous or mental condition that is:

(i) A clinically significant behavioral or psychological syndrome or pattern;
(ii) Associated with
  (a) A present distress or painful symptom;
  (b) A disability or impairment in one or more important areas of functioning; or
  (c) A significantly increased risk of suffering death, pain disability or an important loss or freedom; and
(iii) Is a condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV)

Participating Provider or Provider
A participating provider is a practitioner, group practice, program or facility whose credentials, including, but not limited to, degree, licensure, certifications and specialists, have been reviewed and found acceptable by ValueOptions to render services to ValueOptions' Members and agrees to accept the plan's pre-established fee, or reasonable charge, as the maximum amount which can be collected for the service rendered.

Prepaid Health Plan*
A prepaid managed care entity that provides less than comprehensive services on an at risk basis or one that provides any benefit package on a non-risk basis.

Social Security Act*
Public Law 74-271, enacted on August 14, 1935, with subsequent amendments. The Social Security Act consists of 20 titles, four of which have been repealed. The HI and SMI programs are authorized by Title XVIII of the Social Security Act.

Substance Abuse**

Impairment in social and occupational functioning resulting from the pathological and "compulsive" use of a substance. The concept is closely related to the definition of substance dependence, which has similar symptoms of impairment but may include evidence of physiological tolerance or withdrawal. Typical symptoms include failure to fulfill major role obligations at work, school or home; recurrent use of the substance in situations where such use is physically hazardous; substance-related legal problems and continued use even though it causes or exaggerates interpersonal problems.

Utilization Management (UM)

The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria. Evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. UM usually includes new actions or decisions based on the overall analysis of the utilization.

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