XI. Claim & Billing Information

A. Claims Submission Requirements

1. **Time Limit for Filing Claims**
   - Initial claims for covered services must be submitted within ninety (90) days of the date of service to be considered for reimbursement. Those submitted beyond the ninety (90) day time limit are denied on the *ValueOptions* provider summary voucher.
   - 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. Please refer to letter L of this Section in this manual for more detailed instructions on submitting claims involving TPL.
2. **Incomplete Claims**
   - Claims are not paid by *ValueOptions* in the case of incorrect or incomplete required data elements.
   - *ValueOptions* notifies the provider, via the provider summary voucher, of those data elements requiring completion or correction. The required data elements and other claim submission requirements are outlined in Section XI.C.1 and XI.C.2 in this manual.

B. Claims Submission Policy

- Original paper claims for covered services in this manual must be submitted directly to:

  ValueOptions
  PO Box 12450
  Norfolk, VA 23541-0450

  Copies of claims and faxed claims are not be accepted as an Initial Claim.
- Detailed instructions on required data elements for completing the claim forms are outlined in Section C (Paper Claims Submission Requirements) below.
- *ValueOptions* accepts claims submitted electronically according to the guidelines contained in the *ValueOptions* EDI Manual. For more details on becoming a *ValueOptions* EDI Submitter, EDI file specifications, as well as information about free EDI software please contact the *ValueOptions* EDI Help Desk at **1-888-247-9311**.
- The provider agreement details the covered services that have been contracted for and the definition of services included in the per diem rates.
- Claims must be submitted with the NorthSTAR ID Number. Failure to use this permanent ID number results in the denial of the claim on the provider summary voucher.
- Claims must be submitted with valid DSM IV or ICD-9-CM diagnosis codes only. Claims submitted with any other diagnosis code are denied on the *ValueOptions* provider summary voucher.

- *ValueOptions* is committed to continuing communication with network providers regarding changes and updates to billing policies and procedures. Future communications are provided as needed through online news and education articles.
- **Please note that providers are NOT permitted to bill TMHP for NorthSTAR enrollees after the NorthSTAR Program begins services which are to be reimbursed under NorthSTAR.**

C. Paper Claim Submission Requirements

- **Forms and Instructions for Completing the CMS 1500 Claim Form can be found in Section XIII (Required Forms) in this manual or online at:** http://www.valueoptions.com/provider/handbooks/forms/administration/cms1500.pdf
- **Additional tips for the CMS 1500 form can be found in Section XIII (Required Forms) in this manual or online at:** http://www.valueoptions.com/provider/handbooks/forms/administration/cms1500tips.pdf
- **Forms and Instructions for Completing the UB92 Claim Form (HCFA 1450) can be found in Section XIII (Required Forms) in this manual or online at:** http://www.valueoptions.com/provider/handbooks/forms/administration/ub92.pdf
- **Additional tips for the UB92 form can be found in Section XIII (Required Forms) in this manual or online at:** http://www.valueoptions.com/provider/handbooks/forms/administration/ub92tips.pdf

1. Valid Discharge Reasons

Listed below are valid discharge reasons. Claims received after December 1, 2004, containing any discharge reason not included on this list, will be denied.

The new denial code is: RCV, Resubmit Claim with Valid Discharge Reason

Discharge Reason Code	Discharge Reason Description
01	Discharge to Home or Self Care
02	Discharge or Transfer to another short term general hospital for inpatient care
03	Discharge or Transfer to skilled nursing facility (SNF)
04	Discharge or Transfer to an Intermediate Care Facility (ICF)
05	Discharge or Transfer to another type institution for Inpatient Care/Referred to Outpatient Services
06	Transfer to home under care of Home Health Services Organization
07	Left against medical advice/discontinued care
08	Discharge or Transfer to home under care of Home IV provider
09	Admitted as inpatient to this hospital
10	Discharge to be defined at state level, if necessary
11	Discharge to be defined at state level, if necessary

12	Discharge to be defined at state level, if necessary
13	Discharge to be defined at state level, if necessary
14	Discharge to be defined at state level, if necessary
15	Discharge to be defined at state level, if necessary
16	Discharge to be defined at state level, if necessary
17	Discharge to be defined at state level, if necessary
18	Discharge to be defined at state level, if necessary
19	Discharge to be defined at state level, if necessary
20	Expired
21	Expired to be defined at state level, if necessary
22	Expired to be defined at state level, if necessary
23	Expired to be defined at state level, if necessary
24	Expired to be defined at state level, if necessary
25	Expired to be defined at state level, if necessary
26	Expired to be defined at state level, if necessary
27	Expired to be defined at state level, if necessary
28	Expired to be defined at state level, if necessary
29	Expired to be defined at state level, if necessary
30	Still a patient/Expected to return for Outpatient Services
31	Still a Patient, to be defined at state level, if necessary
32	Still a Patient, to be defined at state level, if necessary
33	Still a Patient, to be defined at state level, if necessary
34	Still a Patient, to be defined at state level, if necessary
35	Still a Patient, to be defined at state level, if necessary
36	Still a Patient, to be defined at state level, if necessary
37	Still a Patient, to be defined at state level, if necessary
38	Still a Patient, to be defined at state level, if necessary
39	Still a Patient, to be defined at state level, if necessary
40	Expired at home
42	Expired - Place Unknown
50	Discharged to Hospice-Home
51	Discharged to Hospice-Medical Facility

2. Non-billable ICD-9 Codes

Listed below are ICD-9 codes that will not be accepted as valid, billable codes. Any claims received after December 1, 2004, containing these codes will be denied.

The general rule for billable codes is if a five digit diagnosis code exists, it must be used, because it is the most specific. For example, 290.10 is a billable code, but 290.1 is not.

Code	Description
V611	COUNSELING-PARTNER PBX
290	DEMENTIAS
290.1	PRESENILE DEMENTIA
290.2	SENILE DELUSION/DEPRESS
290.4	VASCULAR DEMENTIA
291	ALC-INDUCED MENTAL DISORDER
291.8	OTH ALC-IND MENTAL DISORDER
292	DRUG-INDUCED MENTAL DISORDER
292.1	DRUG-IND PSYCHOTIC DISORDER
292.8	OTHER DRUG MENTAL DISORDER
293	TRANS MENTAL DIS D/T CCE
293.8	OTH TRANS MENTAL DIS CCE
294	PERSIST MENT DIS D/T CCE
294.1	DEMENTIA IN OTH DISEASES
295	SCHIZOPHRENIC DISORDERS
295.0	SIMPLE SCHIZOPHRENIA
295.1	HEBEPHRENIA
295.2	CATATONIC SCHIZOPHRENIA
295.3	PARANOID SCHIZOPHRENIA
295.4	SCHIZOPHRENIFORM DISORDER
295.5	LATENT SCHIZOPHRENIA
295.6	RESID TYPE SCHIZ DISORDER
295.7	SCHIZOAFFECTIVE DISORDER
295.8	SCHIZOPHRENIA NEC
295.9	SCHIZOPHRENIA NOS
296	EPISODIC MOOD DISORDER
296.0	BPI-SNGL MANIC EPISODE
296.1	RECUR MANIC DISORDER
296.2	MDD SINGLE EPISODE
296.3	MDD-RECURRENT EPISODE
296.4	BPI-RECENT MANIC EPISODE
296.5	BPI-RECENT DEPR EPISODE
296.6	BPI-RECENT MIXED EPISODE
296.8	BIPOLAR DISORDER NEC&NOS
296.9	EPISOD MOOD DIS NEC&NOS
297	DELUSIONAL DISORDERS
298	OTHER NONORGANIC PSYCHOSES

299 PERVASIVE DEVEL DISORDER
299.0 AUTISTIC DISORDER
299.1 CHILD DISINTEGR DISORDER
299.8 OTHER PERVASIVE LEVEL DISORDERS
299.9 PERVASIVE DEVEL DISORDER NOS
300 ANX/DISSOC/SOMAT DISORDER
300.0 ANXIETY STATES
300.1 DISSOC/CONV/FACTIT DISORDER
300.2 PHOBIC DISORDERS
300.8 SOMATOFORM DISORDERS
301 PERSONALITY DISORDERS
301.1 AFFECTIVE PERSONALITY
301.2 SCHIZOID PERSONALITY
301.5 HISTRIONIC PERSONALITY
301.8 OTHER PERSONALITY DISORDER
302 SEX/GENDER ID DISORDERS
302.5 TRANS-SEXUALISM
302.7 PSYCHOSEXUAL DYSFUNCTION
302.8 PSYCHOSEXUAL DISORDER NEC
303 ALCOHOL DEPENDENCE SYNDROME
303.0 AC ALCOHOL INTOXICATION
303.9 ALCOHOL DEP NEC & NOS
304 DRUG DEPENDENCE
304.0 OPIOID TYPE DEPENDENCE
304.1 SEDATIVE/HYPNOTIC DEPENDENCE
304.2 COCAINE DEPENDENCE
304.3 CANNABIS DEPENDENCE
304.4 AMPHETAMINE DEPENDENCE
304.5 HALLUCINOGEN DEPENDENCE
304.6 DRUG DEPENDENCE NEC
304.7 OPIOID/OTHER DRUG DEPENDENCE
304.8 COMB DRUG DEPENDENCE NEC
304.9 DRUG DEPENDENCE NOS
305 NONDEPENDENT DRUG ABUSE
305.0 ALCOHOL ABUSE
305.2 CANNABIS ABUSE
305.3 HALLUCINOGEN ABUSE
305.4 SEDATIVE/HYPNOTIC ABUSE
305.5 OPIOID ABUSE
305.6 COCAINE ABUSE
305.7 AMPHETAMINE ABUSE
305.8 ANTIDEPRESSANT ABUSE
305.9 DRUG ABUSE NEC & NOS
306 PSYCHOPHYSIOLOGIC PBX
306.5 PSYCHOGENIC GU DISEASE
307 SPECIAL SYMPTOM NEC

307.2 TICS
307.4 NONORGANIC SLEEP DISORDER
307.5 EATING DISORDER NEC & NOS
308 ACUTE REACTION TO STRESS
309 ADJUSTMENT REACTION
309.2 ADJUST RXN/OTH EMOTION
309.8 OTHER ADJUST REACTION
312 CONDUCT DISTURBANCE NEC
312.0 UNSOCIALIZED AGGRESSION
312.1 UNSOCIAL UNAGGRESSION
312.2 SOCIAL CONDUCT DISORDER
312.3 IMPULSE CONTROL DISORDER
312.8 OTHER CONDUCT DISTURBANCE
313 EMOTIONAL DIS CHILD/ADOLESCENT
313.2 SENSITIVITY & WITHDRAWAL
313.8 OTHER EMOTIONAL PBX CHILD
314 HYPERKINETIC SYNDROME
314.0 ADD CHILDHOOD
315 SPECIFIC DEVELOP DELAYS
315.0 DEVELOP READING DISORDER
315.3 SPEECH/LANGUAGE DISORDER
318 OTHER MENTAL RETARDATION

D. Electronic Media Claim Submission Requirements, Filing and Status Inquiries

A provider may access electronic claims by logging on to *ValueOptions*.com and use the online eProvider Submissions Manual to submit and check claims status. Please refer to the EDI/837 HIPAA Compliant Claims Submission Manual for specific guidelines and requirements. Questions may be directed to the EDI Help Line at, 1-888-247-9311.

E. State Requirements for Claims Turnaround Time

ValueOptions adjudicates (i.e., pay or deny) 100% of clean claims (error-free claims) submitted by providers within thirty (30) days from the date the clean claim is received.

ValueOptions pays providers' interest on clean claims received that are not adjudicated within thirty (30) days from the date the clean claim is received. Interest is paid at the rate of 1.5% per month (18% annual) for each month the clean claim's adjudication remains outstanding.

F. Claims Appeal Process

You have the right to request reconsideration or appeal of a claims payment. A claim appeal is managed through the administrative appeal process.

Your request for reconsideration of a claim should include a cover letter detailing the reasons that you are requesting an appeal, a copy of the original claim, and a copy of the corresponding remittance advice.

ValueOptions must receive your request for reconsideration within sixty(60) days from the date the claim appears on your ValueOptions remittance statement.

Claims/Administrative appeals should be mailed to:

ValueOptions
Attn: Public Sector Appeals Coordinator
1199 South Belt Line Road, Suite 100
Coppell, TX 75019

ValueOptions has thirty (30) days to respond to your request.

If you have exhausted the appeals process at *ValueOptions*, but feel that you have not received due process or adequate resolution, you may contact the State's NorthSTAR Provider and Enrollee Department at (512) 206-4761. If you contact the State's NorthSTAR Provider and Enrollee department prior to completing the *ValueOptions* appeal process, you will be directed back to *ValueOptions*.

G. *ValueOptions'* Provider Summary Voucher

***ValueOptions'* Provider Summary Voucher-** It is *ValueOptions' expectation* that all providers review their summary vouchers and post payments back to their billing ledgers. Summary vouchers are provided with all payments. Please contact *ValueOptions* at 1-888-800-6799 if training or additional assistance is needed to understand the summary vouchers. *ValueOptions* is developing Electronic Remittance Advise (Electronic Summary Vouchers) and will make these available to all providers once the technology is complete.

Sample EOB/Summary Voucher for Providers

CHECK PAGE

PROFILE: S13 DATE: 06/01/98	CHECK #: 003328 CHECK AMOUNT: 385.00
COMPANY NAME ADDRESS CITY, ST ZIP CODE	

EXPLANATION OF PAYMENT CODES:

B6 - TRANSITION BENEFITS APPLIED
JP - RESUBMIT CLAIM WITH VALID PROCEDURE CODE
FE - ADJUSTED; MEMBER NOT ELIGIBLE

COMPANY NAME
ADDRESS
CITY, ST ZIP CODE

Bank Name
City, State

00-00
000

DATE	CHECK NUMBER	AMOUNT
06/01/98	003328	****385.00*

PAY **$3 HUNDRED 85 DOLLARS AND 50 CENTS**

TO THE ORDER OF

COMPANY NAME
ADDRESS
CITY, ST ZIP CODE

AUTHORIZED SIGNATURE

** INSERT MICR CODE HERE ***

A

PROVIDER SUMMARY VOUCHER

PAGE 1

ACCOUNT NAME
SERVICE CENTER NAME
ADDRESS
CITY, ST ZIP
(999) 999-9999

B

PROVIDER NAME
PRACTICE NAME
PRACTICE STREET ADDRESS
CITY, ST ZIP CODE

DATE: 06/01/98
PROFILE: S13
VENDOR #: A032095
CHECK #: 003328
CHECK AMOUNT: 385.00

C

PROVIDER: PROVIDER NAME **PROVIDER NUMBER: 666777**

D

DATE OF SERVICE	PROC CODE	MOD COD	CHARGED AMOUNT	ALLOWED AMOUNT	PROVIDER WITHHOLD	DISCOUNT AMOUNT	COB	PREPAID AMOUNT	NON COVRD AMOUNT	DEDUCTIBLE AMOUNT	CO PAY AMOUNT	CO INS AMOUNT	AMOUNT PAID	OTHER INS	EOP CODES
PATIENT NAME: John Doe 1 MEMBER ID #: P67250301 PATIENT #: 2808661 PARENT CODE: COM CLAIM NO: 0109166720133															
0407-040798	90844		95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46.50	0.00	B6
0413-041398	90844		95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46.50	0.00	B6
CLAIM TOTAL:			190.00	93.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	93.00	0.00	
PATIENT NAME: John Doe 2 MEMBER ID #: K01326DD1 PATIENT #: 2808022 PARENT CODE: COM CLAIM NO: 0109166720132															
0402-040298	90844		95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46.50	0.00	
0407-040798	90844		95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46.50	0.00	
0412-041298	90844		95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46.50	0.00	
0415-041598	90844		95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46.50	0.00	
0422-042298	90844		95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46.50	0.00	
0427-042798	90844		95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46.50	0.00	
CLAIM TOTAL:			570.00	279.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	279.00	0.00	
PATIENT NAME: Jane Doe 1 MEMBER ID #: K01327301 PATIENT #: 2808541 PARENT CODE: COM CLAIM NO: 0109166720131															
0402-040298	90844		95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46.50	0.00	
0407-040798	90844		95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46.50	0.00	
0412-041298	90844		95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46.50	0.00	
0415-041598	90844		95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46.50	0.00	
0422-042298	90844		95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46.50	0.00	
0427-042798	90844		95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46.50	0.00	
CLAIM TOTAL:			570.00	279.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	279.00	0.00	
PATIENT NAME: Jane Doe 2 MEMBER ID #: K01326701 PATIENT #: 2808141 PARENT CODE: COM CLAIM NO: 0109166720129															
0405-040598	UNK		95.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	JP
CLAIM TOTAL:			95.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
PATIENT NAME: John Doe 3 MEMBER ID #: 57380667503 PATIENT #: 97046 1 PARENT CODE: COM CLAIM NO: 0112046704905															
0315-031598	90844		95.00	63.25	0.00	0.00	0.00	0.00	3.25	0.00	10.00	0.00	50.00	0.00	
0315-031598	90844		95.00	63.25	0.00	0.00	0.00	0.00	3.25	0.00	10.00	0.00	50.00	0.00	
CLAIM TOTAL:			190.00	126.50	0.00	0.00	0.00	0.00	6.50	0.00	20.00	0.00	100.00	0.00	
PATIENT NAME: Jane Doe 3 MEMBER ID #: 05062806501 PATIENT #: PARENT CODE: COM CLAIM NO: 0111079522237															
0401-040198	90801		101.00-	101.00-	0.00	0.00	0.00	0.00	0.00	0.00	5.00-	0.00	96.00-	0.00	FE
0404-040498	90844		95.00-	95.00-	0.00	0.00	0.00	0.00	0.00	0.00	5.00-	0.00	90.00-	0.00	FE
0407-040798	90844		95.00-	95.00-	0.00	0.00	0.00	0.00	0.00	0.00	5.00-	0.00	90.00-	0.00	FE
0411-041198	90844		95.00-	95.00-	0.00	0.00	0.00	0.00	0.00	0.00	5.00-	0.00	90.00-	0.00	FE
CLAIM TOTAL:			386.00-	386.00-	0.00	0.00	0.00	0.00	0.00	0.00	20.00-	0.00	366.00-	0.00	

SAMPLE

E

TOTAL PAID FOR THIS PROVIDER: 385.00

THIS SPACE IS RESERVED FOR A GENERAL COMMENT. (The comment may be customized for the Client)
Claim resubmissions must be received within 60 days from the Date, listed at the top of this summary voucher.

H. Provider Summary Voucher Key:

Notes	Field	Description
A	COMPANY NAME	The Service Center specific address and telephone number to direct customer service related questions and correspondences.
B	PROVIDER INFORMATION	The provider's billing location name and address.
C	PARENT CODE	An internal code that defines the client associated with the patient.
D	COLUMN HEADINGS	Detailed information to assist in understanding how the claim was processed.
	1. DATE OF SERVICE	The date(s) that services were rendered to the patient.
	2. PROC CODE	The CPT4 or revenue code that describes the service rendered.
	3. MOD COD	The code used by a provider indicating that a service or procedure has been customized but not changed in its definition or code.
	4. CHARGED AMOUNT	The amount billed by the provider for the service rendered.
	5. ALLOWED AMOUNT	The client's allowed amount for the service rendered.
	6. PROVIDER WITHHOLD	A contractual amount withheld from the provider's payment which should not be billed to the patient.
	7. DISCOUNT AMOUNT	A negotiated amount with the provider indicating the payment will be reduced by an agreed upon percentage.
	8. COB	The amount recovered as the result of not being the primary payer of benefits.
	9. PREPAID AMOUNT	The amount paid to the provider prior to the service being rendered.
	10. NON-COVERED AMOUNT	The amount not covered.
	11. DEDUCTIBLE AMOUNT	The amount applied to the deductible.
	12. CO-PAY AMOUNT	A fixed dollar amount due to the provider from the patient.
	13. CO-INSURANCE	A percentage of the allowed amount due to the provider from the patient.
	14. AMOUNT PAID	The amount paid by our company on the claim.
	15. OTHER INSURANCE	The amount paid by the primary insurance carrier.
	16. EOP CODES	The explanation of payment code(s).
E	MESSAGE AREA	Customized message area.

I. Co-Pay Policy

1. Applicable Population

Non-Medicaid eligible enrollees whose income is 150% above the current Federal Poverty Level (FPL) may be charged co-payments in accordance with the State's family-income based co-payment schedule. It is the responsibility of the provider to collect the co-payment from the enrollee, and report the amounts collected to *ValueOptions*. The co-payment is not deducted from the amount reimbursed by *ValueOptions*. However, it must be reported in block 29 on the HCFA 1500 claim form, and block 84 on the UB92 claim form. The maximum co-payment amount that can be collected from a family on a monthly basis is listed in the Standard Sliding Fee Schedule, on the next page.

2. Standard Sliding Fee Schedule:

412-C
Exhibit A

TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION
MONTHLY ABILITY-TO-PAY FEE SCHEDULE

Annual Gross Income	Monthly Gross Income	Maximum Monthly Fee By Family Size 1	2	3	4	5	6	7	8	9+	% monthly income family size 1
8,980	748	0	0	0	0	0	0	0	0	0	
13,470	1,123	28	0	0	0	0	0	0	0	0	2.50%
15,040	1,253	33	0	0	0	0	0	0	0	0	2.66%
16,610	1,384	39	0	0	0	0	0	0	0	0	2.82%
18,180	1,515	45	28	0	0	0	0	0	0	0	2.98%
19,750	1,646	52	33	0	0	0	0	0	0	0	3.14%
21,320	1,777	59	39	0	0	0	0	0	0	0	3.30%
22,890	1,908	66	45	28	0	0	0	0	0	0	3.46%
24,460	2,038	74	52	33	0	0	0	0	0	0	3.62%
26,030	2,169	82	59	39	0	0	0	0	0	0	3.78%
27,600	2,300	91	66	45	28	0	0	0	0	0	3.94%
29,170	2,431	100	74	52	33	0	0	0	0	0	4.10%
30,740	2,562	109	82	59	39	0	0	0	0	0	4.26%
32,310	2,693	119	91	66	45	28	0	0	0	0	4.42%
33,880	2,823	129	100	74	52	33	0	0	0	0	4.58%
35,450	2,954	140	109	82	59	39	0	0	0	0	4.74%
37,020	3,085	151	119	91	66	45	28	0	0	0	4.90%
38,590	3,216	163	129	100	74	52	33	0	0	0	5.06%
40,160	3,347	175	140	109	82	59	39	0	0	0	5.22%
41,730	3,478	187	151	119	91	66	45	28	0	0	5.38%
43,300	3,608	200	163	129	100	74	52	33	0	0	5.54%
44,870	3,739	213	175	140	109	82	59	39	0	0	5.70%
46,440	3,870	227	187	151	119	91	66	45	28	0	5.86%
48,010	4,001	241	200	163	129	100	74	52	33	0	6.02%
49,580	4,132	255	213	175	140	109	82	59	39	0	6.18%
51,150	4,263	270	227	187	151	119	91	66	45	28	6.34%
52,720	4,393	286	241	200	163	129	100	74	52	33	6.50%
54,290	4,524	301	255	213	175	140	109	82	59	39	6.66%
55,860	4,655	317	270	227	187	151	119	91	66	45	6.82%
57,430	4,786	334	286	241	200	163	129	100	74	52	6.98%
59,000	4,917	351	301	255	213	175	140	109	82	59	7.14%
60,570	5,048	368	317	270	227	187	151	119	91	66	7.30%
62,140	5,178	386	334	286	241	200	163	129	100	74	7.46%
63,710	5,309	405	351	301	255	213	175	140	109	82	7.62%
65,280	5,440	423	368	317	270	227	187	151	119	91	7.78%
66,850	5,571	442	386	334	286	241	200	163	129	100	7.94%
68,420	5,702	462	405	351	301	255	213	175	140	109	8.10%
69,990	5,833	482	423	368	317	270	227	187	151	119	8.26%
71,560	5,963	502	442	386	334	286	241	200	163	129	8.42%
73,130	6,094	523	462	405	351	301	255	213	175	140	8.58%
74,700	6,225	544	482	423	368	317	270	227	187	151	8.74%
76,270	6,356	566	502	442	386	334	286	241	200	163	8.90%
77,840	6,487	588	523	462	405	351	301	255	213	175	9.06%
79,410	6,618	610	544	482	423	368	317	270	227	187	9.22%
80,980	6,748	633	566	502	442	386	334	286	241	200	9.38%
82,550	6,879	656	588	523	462	405	351	301	255	213	9.54%
84,120	7,010	680	610	544	482	423	368	317	270	227	9.70%
85,690	7,141	704	633	566	502	442	386	334	286	241	9.86%
87,260	7,272	729	656	588	523	462	405	351	301	255	10.02%
88,830	7,403	754	680	610	544	482	423	368	317	270	10.18%
90,400	7,533	779	704	633	566	502	442	386	334	286	10.34%
91,970	7,664	805	729	656	588	523	462	405	351	301	10.50%
93,540	7,795	831	754	680	610	544	482	423	368	317	10.66%
95,110	7,926	858	779	704	633	566	502	442	386	334	10.82%
96,650	8,054	884	805	729	656	588	523	462	405	351	10.98%
98,190	8,183	912	831	754	680	610	544	482	423	368	11.14%
99,730	8,311	939	858	779	704	633	566	502	442	386	11.30%

Source: 2003 Federal Poverty Guidelines, February 7, 2003, Federal Register, vol. 68, No. 26, pp. 6456-6458

EFFECTIVE: September 1, 2003

J. Third Party Liability (TPL)

- Providers must exhaust all avenues of other insurance coverage and payment prior to billing *ValueOptions* for covered services.
- *ValueOptions* is the payer of last resort in the event any one or more third party payers are responsible for covered services provided to enrolled and eligible persons (enrollees).
- *ValueOptions'* service authorization procedures outlined in Section IV of this manual must be followed when providing services to an enrollee identified with TPL.
- For any eligible enrollee with reimbursable TPL, the third party insurance carrier must be billed prior to billing *ValueOptions*. Once the TPL carrier has responded, *ValueOptions* may then be billed. TPL claims for eligible enrollees must be submitted on a completed standard HCFA 1500 or UB92 claim form. The claim form, along with a copy of the Explanation of Benefits or Summary Voucher received from the third party insurance carrier must be mailed to *ValueOptions*.
- All claims involving Third Party Liability must be submitted within ninety (90) days of the date of the other carrier's EOB or notification of payment/denial, to be considered for reimbursement.
- Additionally, if it is determined that an enrollee had relevant third party coverage after *ValueOptions* has been billed, the third party insurer must be billed. Once the EOB / Summary Voucher is received, an adjustment request for the applicable claim and a copy of the relevant *ValueOptions* and Third Party EOB/Summary Voucher must be sent to *ValueOptions* according to the procedures outlined in Section XI. (M. Adjustment/ Reversal Requests).

1. Additional TPL Billing Instructions

- One copy of the EOB/Summary Voucher must be attached to each applicable claim.
- Ensure that the level of detail on the claim corresponds to the EOB/Summary Voucher from the primary carrier.
- If there are multiple third party carriers, all relevant EOBs/Summary Vouchers must be attached to the claim.
- Amounts paid by the other third party carrier should be documented in:
  - Block # 24K on the HCFA 1500 (Reserved for Local Use Only block)
  - Block # 54 on the UB92 (Prior Payments)

K. Adjustment/Reversal Requests

- Claims requiring reconsideration of payment amounts for any reason must be resubmitted to *ValueOptions* via one of the methods below:

- ○ An Adjustment Request Form within sixty (60) days from the date of the Summary Voucher. (Electronic submissions of this form will not be accepted.)
- ○ Resubmitted by electronic spreadsheet within sixty (60) days from the date of the Summary Voucher**. The Provider must utilize the standard electronic spreadsheet format found in Required Forms section of this manual.** Spreadsheets that are not submitted in the standard electronic spreadsheet format will not be processed and will be returned. A standard electronic spreadsheet format can be requested from Enrollee/Provider Services at 1-888-800-6799. Please email completed spreadsheets to: ClaimsAdjust@*Valueoptions*.com

The Adjustment Form can be found in Section XIII (Required Forms). One form must be completed for each original claim being adjusted. All items on the form are required. Forms that are incomplete are not processed and are returned.
Please mail completed forms to:

ValueOptions
ATTN: Adjustment Unit
PO Box 12450
Norfolk, VA 23541-0450

1. Re-Submissions

- Claims not paid by *ValueOptions* due to incorrect or incomplete required data elements must be resubmitted for payment consideration within sixty (60) days from the date on the Summary Voucher.
- Providers may resubmit corrected claims (which were denied for incomplete or incorrect required data elements) by mail.
- Providers should submit the claim number from the original claim on the resubmitted claim in:
  - ○ Block 19 on the HCFA 1500
  - ○ Block 37a on the UB92

2. Definitions for Frequency

- **Non Payment / Zero Claim (0)**

  This code is to be used when a bill is submitted to a payer, but the provider does not anticipate a payment as a result of submitting the bill; but needs to inform the payer of the non-reimbursable periods of confinement or termination of care.

- **Admit Through Discharge Claim (1)**

  This code is to be used for a bill which is expected to be the only bill to be received for a course of treatment or inpatient confinement. This includes bills representing a total

confinement or course of treatment, and bills which represent an entire benefit period of the primary third party payer.

- **Interim – First Claim (2)**

  This code is to be used for the first of a series of bills to the same third party payer for the same confinement or course of treatment.

- **Interim – Continuing Claim (3)**

  This code is to be used when a bill for the same confinement or course of treatment has previously been submitted and it is expected that further bills for the same confinement or course of treatment are to be submitted.

- **Interim – Last Claim (4)**
  - This code is to be used for the last of a series of bills, for which payment is expected, to the same third party payer for the same confinement or course of treatment.
  - Note, this code is not intended to be used in lieu of a code for Late Charges, Adjustments or Zero / Non-Payment Claims.

- **Late Charge(s) Only (5)**
  - This code is to be used for submitting charges to the payer which were received by the provider after the Admit through Discharge to the Last Interim Claim has been submitted.
  - Note, this code is not intended to be used in lieu of an Adjustment Claim or a Replacement Claim.

- **Adjustment of a Prior Claim (6)**
  - This code is to be used when a specific bill has been issued for a specific Provider, Patient, Payer, Insured and "Statement Covers Period" date and the reimbursement amount is to be recalculated through an increase or decrease in charges, per diem calculations, deductibles, co-insurance, and/or prior third party payments,
  - To properly adjust a prior bill, the respective plus or minus adjustment must be provided, along with the net overall charge and the new reimbursement amount.
  - Where a revenue code line is to be changed, the provider is to operate on the principle that the change is to be added to information already submitted (new charge line is unsigned) or is to be subtracted from information already submitted (new charge line is a credit).
  - Note, this code is not intended to be used in lieu of a Late Charge(s) Only claim.

- **Replacement of a Prior Claim (7)**
  - This code is to be used when a specific bill has been issued for a specific Provider, Patient, Payer, Insured, and "Statement Covers Period" and it needs to be restated in its entirety, except for the same identifying information. In using this code, the payer is to operate on the principal that the original bill is null and void, and that the information present on this bill represents a complete replacement of the previously issued bill.
  - Note, this code is not intended to be used in lieu of the Late Charge(s) Only claim.
- **Void / Cancel of Prior Claim (8)**

  This code reflects the elimination in its entirety of a previously submitted bill for a specific Provider, Patient, Payer, Insured and "Statement Covers Period" dates. The provider may wish to follow a Void Bill with a bill containing the correct information when a Payer is unable to process a Replacement to a Prior Claim. The appropriate Frequency Code must be used when submitting the new bill.

3. Incomplete Claims

- Claims are not paid by *ValueOptions* in the case of incorrect or incomplete required data elements.
- *ValueOptions* notifies the provider via the Provider Summary Voucher, of those data elements requiring completion or correction. The required data elements and other claim submission requirements are outlined in Section XI.C (Paper Claims Submission Requirements) in this manual. Electronic Media Claims submission guidelines are contained in the EDI/837 HIPAA Compliant Claims Submission Manual.

L. Billing Chart

For assistance in determining how to complete a clean claim the grid on the next page provides all the procedure codes and information needed for a claim.

See the Service Class Grid on the following page.