



- Your provider number is your unique six digit number (e.g. 123456) which identifies you as a contracted provider.
- Your vendor number is a service location number where the service was rendered. You may have multiple vendor locations and each vendor location is given a five-digit number preceded by the letter 'A'. (e.g. A23456)

If you do not have these numbers, contact our toll-free National Provider Line at **(800) 397-1630** during normal business hours, Monday through Friday, between 8:00 AM and 5:00 PM EST, for assistance.

Failure to report changes in a timely manner can adversely affect participation in the network and may result in claims payments being delayed.

**NOTE:** With the implementation of NPI on May 23, 2007, business rules for new claims submission will be implemented. Information about VOC' submission process is located at [www.valueoptions.com](http://www.valueoptions.com).

### **Provider/Member Relationship**

Nothing in our relationship changes or alters any clinical relationship that exists or may come to exist between a provider and any member(s). The provider shall always exercise his/her/its best medical judgment in the treatment of members; payment determinations by VOC or payers shall not be construed as a directive from VOC that medically necessary treatment be withheld. The provider will not be prohibited from or penalized for a communication between provider and members regarding available treatment options, including appropriate or medically necessary care for the member.

### **Provider Responsibilities**

Providers have an independent responsibility to provide mental health and/or substance abuse services to members in care. Only independently licensed clinicians are to render service to our members. Practitioners who are supervised by a clinician should reference their credentialing application as a guideline. Coverage or payment determinations by VOC in no way absolve a provider of responsibility to render appropriate services.

Providers must:

- Verify member eligibility and benefits prior to rendering services.
- Preauthorize care when required, prior to rendering services.
- Verify coverage with VOC members for coordination of benefits.
- Provide quality services that are medically necessary to eligible members.
- Collect members' co-payment/deductible at the time of service.

- Provide continuous care for members or arrange for on-call coverage by a practitioner within the VOC network.
- Adhere to the accessibility and availability standards established by VOC.
- Ensure equal treatment of all VOC members, regardless of product.
- Ensure VOC has the most current practice/facility information as it relates to contract agreement.
- Notify VOC of potential inpatient discharge problems.
- Advise members of financial responsibility regarding services that are not covered, prior to rendering such service.
- Notify VOC of potential Care Management patients.
- Coordinate care with a member's other health/medical care provider(s), either behavioral and/or medical providers who are treating the same or related (co-morbid) condition to assure continuity and appropriate coordination of care. Providers will be expected to provide coordination of care while maintaining confidentiality and assuring safeguards of the member's protected health information (PHI).
- Refer members to participating providers/facilities when alternative or different mental health or substance abuse services are required.
- Submit claims on behalf of members.
- Upon written request by VOC, submit copies of member medical records without charge.

### **Professional Standards**

Providers must render covered services in a quality and cost-effective manner recognizing VOC standards and procedures (as described in this Provider Handbook); in accordance with generally accepted medical standards and all applicable laws and regulations; and pursuant to the same standards as services rendered to provider's other members. Providers must not discriminate against any member on the basis of race, color, gender, sexual orientation, age, religion, national origin, handicap, health status or source of payment in providing services under their provider agreement.

### **The Americans With Disabilities Act**

VOC expects providers to comply with all provisions of The Americans with Disabilities Act (ADA) and other federal, state or local laws or municipal codes applicable to VOC services. Services should be handicap-accessible for physically, visually, and hearing impaired participants. Providers are encouraged to adapt their environment to meet the special needs of members. Accessibility of services is an integral component to meeting need equitably. Providers should attempt to deploy and adapt their office or facility space so that they are usable by all those in need and otherwise eligible. This includes providing or arranging for communication assistance for persons with special needs, who have difficulties making their service needs

known, by providing assistance such as a computer, telephone amplification, sign language services, or other communication methods to facilitate service.

### **Prohibition of “Balance Billing”**

Providers agree that in no event, including, but not limited to, nonpayment by VOC, insolvency of VOC or breach of the provider/facility agreement with VOC, shall they 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 the provider agreement.

Providers may not bill members for services to be paid for by VOC or for non-authorized services. This practice is known as “balance-billing.” Providers who knowingly “balance bill” VOC members are subject to provider sanctions. The provider also agrees that this provision supersedes any oral or written contrary agreement previously entered into between the provider and member.

Providers may only collect applicable deductibles, coinsurance and/or co-payments from the member at the time of services. VOC will reimburse the provider the balance up to the fee schedule maximum or negotiated rate or the billed charge (whichever is less) for covered services upon receipt of a clean claim form in compliance with VOC policies and procedures. Coordination of benefits and deductibles vary by contract. VOC will not reimburse a provider if a service is a non-credentialed and/or non-contracted Covered Benefit. A VOC provider may request reimbursement from an existing VOC member if the member has met their benefits maximum. However, a member is not required to reimburse a provider more than the contracted reimbursement rate for contracted services where the benefits have been exhausted.

### **The following situations are *not* considered “balance-billing”:**

- Payments, full or partial, required for non-cancelled or missed appointments when the member has given prior consent, preferably in writing, to such charges. State laws and provider benefit plans vary as to the acceptability of billing for missed appointments.
- When members contract with a provider to self-pay for services not covered under their benefit plan.
- Billing members who continue to have services provided after their yearly benefit maximums have been knowingly reached.

NOTE: In all the above circumstances, providers are strongly encouraged to have such payments by members agreed to in writing by the member prior to the service being rendered and/or billed.

### **Reporting Material Changes Relating to Credentialing or Recredentialing Process**

VOC providers are required to report material changes to information that was submitted to VOC as part of the credentialing or recredentialing process to our National Provider Line at (800) 397-

1630 from 8 am - 5 pm Eastern Standard Time. **Except as noted below, all information must be reported in writing within five (5) business days of the provider becoming aware of the information.** These changes include, but are not limited to:

1. Material changes to information that was submitted to
  - a. Any action against any of its licenses and/or accreditation by JCAHO, CARF, AOA, COA or any successor thereof.
  - b. Any changes in ownership or business address.
  - c. Any legal or government action initiated that could materially affect the rendering of services in connection with this agreement.
  - d. Any legal action commenced by or on behalf of a VOC' member against provider.
  - e. Any initiation of bankruptcy or insolvency proceedings with regard to provider, whether voluntary or involuntary.
  - f. Any other occurrence known to provider that could materially affect the rendering of services in connection with the provider agreement.
  - g. Discovery that a claim, suit or criminal or administrative proceeding is being brought against the provider relating to the provider's malpractice, compliance with community standards and applicable laws, including any action by licensing or accreditation authorities and exclusions from government programs (i.e. Medicare/Medicaid).
  - h. Expiration of required professional liability insurance coverage (must be reported within 30 days prior to the expiration of such coverage).
  - i. Any changes in demographic information or changes in practice patterns such as change of address, name change, coverage arrangements, tax identification number, hours of operation, and etc. (*Note: If a provider moves to another state, a copy of the provider's license and malpractice is also needed in order to complete a primary source verification.*)
  - j. Expiration of professional license/certification, DEA certificate, CDS certificate, board certification and malpractice insurance. Current copies must be submitted within five (5) days of expiration. Failure to comply may result in immediate disenrollment from the network.

### **Adverse Incident Reporting**

Providers are required to report to VOC within 24 hours all "adverse incidents" involving VOC members. Adverse incidents are defined as "occurrences that represent actual or potential serious harm to the well being of a VOC member, or to others by a VOC member who is in active behavioral health treatment/EAP services, or has been recently discharged (i.e. within the past 12 months) from behavioral health treatment/EAP services." Report all adverse incidents to the Clinical Care Manager with whom you conduct reviews.

Examples of reportable adverse incidents include, but are not limited to:

- Self inflicted harm requiring urgent or emergent intervention (e.g., self-mutilation or attempted suicide)
- Unanticipated death occurring in any setting (e.g., suicide, homicide, death by medical cause)
- Violent/Assaultive behavior occurring in a behavioral health treatment setting and requiring urgent or emergent medical intervention (e.g., attempted murder, physical assault)
- Serious adverse reaction to treatment requiring urgent or emergent treatment in response (e.g. neuroleptic malignant syndrome, tardive dyskinesia, other serious drug reaction)
- Sexual behavior with other patients or staff, whether consensual or not, while in a behavioral health treatment setting.
- Elopements from a behavioral health treatment setting when the patient is considered or alleged to be a danger to self or others.
- Injuries (e.g. accidents) in a behavioral health treatment setting that require urgent or emergent medical treatment
- Property damage, including that which occurs secondary to the setting of a fire, due to the intentional actions of a VOC member while in a behavioral health treatment setting
- Medication errors resulting in the need for urgent or emergent medical intervention.
- Human Rights Violations (e.g. neglect, exploitation)
- Other occurrences representing actual or potential serious harm to a member not listed above (e.g. staff misconduct, unexpected closure of a facility).

Provider reports of adverse incidents are treated confidentially and are processed in accordance with “peer protection” statutes. Based on the circumstances of each incident, or any identified trend of incidents, VOC may undertake an investigation designed to ensure member safety. As a result, providers may be asked to furnish records, and/or engage in corrective action to address any identified or suspected deviations from a reasonable standard of care. *Providers may also be subject to disciplinary action through the VOC Credentialing Committee based on the findings of an investigation or any failure to cooperate with a request for information pursuant to an adverse incident investigation.*

### **Availability Standards**

VOC, our clients, and national accrediting bodies place a high value on the ability of members to access care in a timely manner, consistent with the severity and intensity of their treatment needs. VOC has adopted the following standards of availability for appointments:

## **Emergencies**

In an emergency situation, the member must be offered the opportunity to be seen in person immediately.

Contracted providers who do not maintain coverage 24 hours per day, seven days per week are required to maintain a system for referring members to a source of emergency assistance during non-business hours. The preferred methods are through a live answering service or an on-call pager system. However, providers may maintain a reliable recorded answering machine system; members experiencing an emergency must be given clear instructions about accessing immediate assistance after hours.

## **Non-Life Threatening Emergent**

When there is significant risk of serious life deterioration such as impending inpatient hospitalization, the member must be seen within six (6) hours of the request.

## **Urgent**

In an urgent situation, a member must be offered the opportunity to be seen within 24 hours of the request.

## **Routine**

In a routine situation, a member must be offered the opportunity to be seen within 7 calendar days of the request for a Mental Health Substance Abuse visit and for an EAP visit, a member must be offered an appointment within 7 calendar days.

## **Cultural Competency**

VOC is committed to exploring and incorporating concepts that ensure a system designed to provide care and services that are delivered in a culturally competent and sensitive manner. VOC incorporates the following principles into its quality management program:

- The importance of culture and diversity;
- The assessment of cross-cultural relations;
- Expansion of cultural knowledge, and
- The adaptation of services to meet the specific cultural and linguistic needs of our members.

The development and operational oversight of the company-wide cultural competency plan are the responsibility of the Corporate Cultural Competency Steering Committee (CCCSC). The CCCSC meets quarterly and includes representatives from the ValueOptions, Inc. departments of utilization management/clinical services, network management/provider relations, information

systems, marketing/sales and quality management. The CCCSC is responsible for building and maintaining VOC's commitment to cultural competency.

## Coordination of Care

VOC recognizes the importance of integrating the delivery of behavioral and physical health services to a given member. To that end, you are strongly encouraged to identify all providers involved in the health care of a member and to inform and coordinate the delivery of care with these providers, provided that the member consents in writing to the release of such specific information. Consent forms can be found at [www.valueoptions.com](http://www.valueoptions.com).

## Treatment Record Reviews

Providers are responsible for maintaining patient treatment records in a manner that is current, comprehensive, detailed, and organized, in order to promote effective patient care and quality review. Providers are required to cooperate with treatment record reviews conducted by VOC. **Provider participation in random treatment record audits is an integral part of VOC's quality management program and is a condition of network participation.**

VOC may conduct treatment record reviews under the following circumstances:

- In response to a specific quality issue or concern that arises;
- To meet account or accreditation requirements mandating review on a periodic basis or upon request; or
- As part of routine quality and billing audits to ensure compliance with standards of the organization and our clients.

For the purposes of a treatment record review, the record includes but is not limited to examination, evaluation, treatment, medication prescription and monitoring, counseling session start and stop times, modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Each progress note should include what psychotherapy techniques were used, and how they benefited the member in reaching his/her treatment goals. The provider's progress notes do not have to include intimate details of the member's problems but do have to meet medical necessity guidelines. These intimate details would be documented within the psychotherapy notes, and kept separate from the member's file. Psychotherapy notes that document or analyze the content of conversation during a private counseling session or a group, joint, or family counseling session may be excluded if they are separated from the rest of the record. This definition is in accordance with 45 CFR 164.501.

VOC will gain access to treatment records by reviewing them at your office, or requesting that photocopied records be forwarded to VOC. Providers will not be reimbursed for copies of medical records requested by VOC. **Prior to treating a VOC member, providers should**

**obtain the member's consent to share their treatment information and record with VOC.** Providers must supply copies of requested records to VOC within five (5) business days of the request. VOC will treat your records confidentially as required by law; photocopied records are destroyed following treatment review. Never send original records as they will not be returned at the completion of the audit. Release from the member is not required for these records to be provided to VOC since HIPAA allows release of records without consent for healthcare payment and operations purposes.

Records are reviewed by licensed clinicians. Treatment records are reviewed through application of an objective instrument during quality reviews. The instrument is continuously under study and revision and VOC reserves the right to alter it as needed. Following the treatment record review, you will receive a written report that details the findings. If necessary, the report will include an Action Plan with specific recommendations that will enable you to more fully comply with VOC' standards for treatment records.

For the purpose of conducting retrospective case review, clinical files pertaining to VOC members should be maintained for the time period detailed in your provider agreement.

### **Treatment Record Standards**

You are required to maintain member records in compliance with the policies and procedures of VOC and accrediting bodies. VOC adheres to standards of accrediting organizations such as the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC) and federal and state regulations. These standards require that "patient records are maintained in a manner that is current, comprehensive, detailed, organized and legible to promote effective patient care and quality review." Treatment records are subject to audit by accrediting and regulatory authorities as part of VOC's accreditation process or regulatory review, and are also subject to random audits by VOC Quality Management Department. (Please visit [www.valueoptions.com](http://www.valueoptions.com) for appropriate form.)

#### **General guidelines:**

- All members' treatment records must contain a bio-psychosocial assessment, treatment plan, follow-up assessments, focus of treatment and disposition/discharge plan. Medical and psychological treatment documentation and progress notes must be current and treatment plans shall be updated as necessary.
- It is necessary that the provider initiating treatment document an initial treatment plan that describes the active target interventions with specific, measurable goals at the proposed level of care, stated in behavioral terms.

### **Specific Treatment Record Standards**

1. Each page in the treatment record contains the member's name or ID number.
2. Each treatment record includes the member's address, employer or school name, home telephone number, work telephone number, emergency contacts, marital status or legal status, appropriate consent forms, and guardianship information if relevant.

3. All entries in the treatment record include the responsible provider's name, professional degree, and relevant identification number, if applicable.
4. All entries in the treatment record are dated.
5. The treatment record is legible to someone other than the writer. (A second surveyor examines any record judged to be illegible by one clinical surveyor).
6. Relevant medical conditions are listed, prominently identified, and revised as appropriate in the treatment record.
7. Presenting problems, along with relevant psychological and social conditions affecting the member's medical and psychiatric status, are documented in the treatment record.
8. Special status situations, such as imminent risk of harm, suicidal ideation, or elopement potential, are prominently noted, documented and revised in the treatment record in compliance with VOC's written protocols.
9. Allergies, adverse reactions or no known allergies are clearly documented in the treatment record.
10. A medical and psychiatric history is documented in the treatment record, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports.
11. For members 12 and older, documentation in the treatment record includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over-the-counter drugs. N/A if the member is under the age of twelve.
12. A mental status evaluation that includes the member's affect, speech, mood, thought content, judgment, insight, attention, concentration, memory and impulse control is documented in the treatment record.
13. A DSM-IV/ICD9 diagnosis, consistent with the presenting problems, history, mental status examination, and/or other assessment data is documented in the treatment record.
14. Treatment plans are consistent with diagnoses and have both objective measurable goals and estimated time frames for goal attainment or problem resolution.
15. The focus of treatment interventions is consistent with the treatment plan goals and objectives.
16. Each treatment record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills. For non-prescribing practitioners, each treatment record indicates what medications have been prescribed and the name of the prescriber. N/A is scored if medications are not prescribed.
17. Informed consent for medication and the member's level of understanding is documented. N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber (e.g., LMFT, PhD).
18. When medication is prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed. N/A is scored if medication is not prescribed or the practitioner being reviewed is not a prescriber (e.g. LMFT, PhD).
19. Progress notes describe member strengths and limitations in achieving treatment plan goals and objectives.
20. Members who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care. N/A is scored if the member is not homicidal, suicidal, or unable to conduct activities of daily living.

21. The treatment record documents preventive services, as appropriate (e.g. relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources).
22. The treatment record documents dates of follow-up appointments or, as appropriate, a discharge plan.
23. There is evidence that the clinical assessment is culturally relevant (i.e. addresses issues relevant to the member's race, religion, ethnicity, age, gender, sexual orientation, level of education, socio-economic level, etc.).
24. There is evidence that the treatment plan is culturally relevant. (i.e., addresses issues relevant to the member's race, religion, ethnicity, age, gender, sexual orientation, level of education, socio-economic level, etc.).
25. There is evidence in the record of coordination of care with the PCP or declination of this coordination by the member.
26. The treatment record has evidence of continuity and coordination of care between behavioral healthcare institutions, ancillary providers and or consultants.
27. The treatment record reflects evidence of coordination of care with other outpatient behavioral health practitioners.
28. The record reflects evidence of coordination with the EAP/employer if a referral was made.

### **Documentation of Psychotherapy Techniques**

*(Note: Please always reference the Current Procedural Terminology (CPT) to ensure the use of proper codes.)*

To properly document therapeutic techniques that are used in psychotherapy sessions, an assessment of the member's mental status alone is not enough to support psychotherapy services. Psychotherapy codes (e.g. 90804; 90806; & 90808), are defined in the CPT manual as including insight-oriented, behavior modifying, and/or supportive techniques. A provider's progress notes should include at least one of these techniques and identify how they were used to help the member's particular problem, and the member's progress to date.

Psychiatrists who bill VOC for individual psychotherapy with medical evaluation and management services (e.g. 90805 & 90807) must not only document an assessment of the member's mental status and medication prescribed, but also include documentation of the psychotherapy portion of the service.

## **Time-Based Codes**

When billing for CPT codes that include timed services in the code description (e.g. 90804; 90805; 90806; 90807; & 90808), the actual time spent must clearly be documented within the member's record.

This time can be documented in a number of ways, as long as it can clearly be identified. Examples of this include documented a session's start and stop times (9:00 -9:50) or duration (50 minutes).

### **Procedure Code 90801**

Diagnostic interview services are billed with procedure code 90801. The CPT Manual defines code 90801 as a psychiatric diagnostic interview examination. This initial assessment should include a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances, other information will be reviewed as an alternative to seeing the member.

Diagnostic Services Interviews (90801) may be covered once, at the outset of the illness or suspected illness. It may be utilized again for the same member if a new episode of illness occurs after a hiatus, or an admission or re-admission, to inpatient status due to complications of the underlying condition.

Due to the nature of these initial visits, the appropriate timeframe for such visit would be in excess of sixty (60) minutes.

**PLEASE NOTE:** The treatment record must reflect the elements outlined in the above description.

### **Procedure Code 90802**

Code 90802 is used principally by child psychiatrists, psychologists, and clinical social workers when they initially evaluate children who do not have the ability to interact with ordinary verbal communication. This code may also apply to the initial evaluation of adult members who have organic mental deficits, or who are mute or catatonic.

As with procedure code 90801, this code includes history, mental status, disposition, and other components as indicated. However with this interactive examination, the treating provider uses inanimate objects, such as dolls or toys for a child, or an interpreter for a deaf person or one who does not speak English.

## **Family Therapy**

A provider may also have contacts with a member's family for purposes other than obtaining background information. Family counseling services are only covered where

the primary purpose of such counseling is the treatment of the member's condition. Family counseling is appropriate when:

- There is a need to observe the member's interaction with their family members; and/or
- There is a need to assess the capability of and/or assist the family members in aiding in the management of the member.

In regard to the appropriate usage of family psychotherapy procedure codes:

- Code 90846 is for family psychotherapy without the member present. When a session is rendered with family members of the identified member present and the member not present, this coding should be used.
- Code 90847 is for family psychotherapy (conjoint psychotherapy) with the member present. When rendering conjoint therapy of any format the appropriate coding must be used.

**Note:** VOC does apply a 45 to 50 minute guideline to family therapy codes.

### Site Visits for Quality Reviews

VOC will conduct site visits at facilities or practitioner's office(s). The criteria for selection of providers to whom site visits are made include:

- **Credentialing/Recredentialing**
  - When a VOC network practitioner who serves 50 or more unduplicated members within 24 months relocates or opens an additional office
  - For all non-accredited facility/organizational providers prior to the initial credentialing decision and every three years prior to the recredentialing decision
  - When a previously accredited facility/organizational provider does not maintain or loses accreditation
  - When a non-accredited facility/organizational provider relocates, opens an additional site or adds a new program
- **Client contract.** A client plan may require site visits to all providers being recruited for the network or rendering care to their specific members.
- **Quality.** A site visit may be conducted as part of monitoring an investigation stemming from a member complaint or other quality issue.

You will be contacted by VOC to arrange a mutually convenient time for the site visit. The site visit will take between 30 and 60 minutes for individual practitioners, and as much as several days for facilities or programs. It is important to note that the site visit process is intended as a consultative and educational process. It allows us the opportunity to acknowledge areas of strength and identify opportunities for improvement in our provider network.

Following the site visit, you will receive a written report that details our findings. If necessary, the report will include an action plan that will provide guidance in areas that you need to strengthen in order to be in compliance with VOC standards.

The instrument currently applied during the site visit is continuously under study and VOC reserves the right to alter it as needed. (Please visit [www.valueoptions.com](http://www.valueoptions.com) for appropriate forms.)

### **Requirement to Respond to VOC Inquiries**

VOC may contact providers with questions, concerns, or feedback. It is crucial to respond to such contacts. Repeated failure to respond can result in sanctions up to and including disenrollment from the network.

### **Provider Compliance with VOC Quality Improvement and Utilization Management Programs**

VOC has developed extensive Continuous Quality Improvement and Utilization Management Programs that ensure that service is of the highest possible quality. These measures include, but are not limited to, clinical criteria, controlled studies, surveys, evaluations and audits. Contracted providers agree to allow oversight, subject to applicable state and federal confidentiality laws. Refusal to cooperate with VOC quality improvement or utilization management activities may adversely affect continued network participation or result in sanctions up to and including disenrollment. Provider participation is an integral part of VOC quality management and utilization management programs and is a condition of network participation.

Your provider agreement states that, as a condition of network participation, you agree to cooperate and comply with VOC quality, claims/billing and utilization management activities and standards.

### **Member Rights and Responsibilities**

It is the policy of VOC to ensure that members are treated in a manner that respects their rights and responsibilities as members. Providers are required to inform VOC members under their care of these rights and responsibilities. The VOC' Member Rights and Responsibilities Statement can be copied and posted or distributed to members at their initial visit. You may also download a copy from the VOC Web site at [www.valueoptions.com](http://www.valueoptions.com) for posting.

### **Member Right to Continuing Course of Treatment When Practitioner Leaves the Network**

When a Participating Provider resigns or is disenrolled from the network, the Participating Provider must continue to provide covered services, at the rate and pursuant to the requirements specified in the Participating Provider/Facility Agreement and to adhere to VOC policies and procedures, to members receiving active treatment at the time of termination until the course of treatment is completed or until VOC makes reasonable and medically appropriate arrangements to have another Participating Provider render such services.

### **Special Circumstances Continuing Care Obligations**

Following the termination of the VOC Participating Provider/Facility Agreement for reasons other than medical disciplinary cause or reason, fraud or other criminal activity, the Participating Provider shall, at the request of the applicable member and in accordance with VOC policies and procedures, continue to provide covered services in Special Circumstances to members as described in this section. Participating Providers shall continue to provide covered services in Special Circumstances to members, at the rates and pursuant to the requirements specified in the Agreement, at the time of termination of the Agreement until the course of treatment is completed in accordance with the time periods listed below. This section shall not require VOC or Participating Providers to cover services or provide benefits that are not otherwise covered under the terms and conditions of the member's VOC subscriber group contract.

### **Time Periods for the Provision of Covered Services in Special Circumstances**

Acute Conditions: Completion of covered services shall be provided for the duration of the acute condition or until the member's benefits are exhausted, whichever comes first.

Serious Chronic Conditions: Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to a Participating Provider, as determined by VOC in consultation with the member and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed 12 months from the provider's contract termination date or until the member's benefits are exhausted, whichever comes first.

Newborn Child: Completion of covered services shall not exceed 12 months from the provider's contract termination date or until the member's benefits are exhausted, whichever comes first.

Surgery/Other Procedure: Performance of a surgery or other procedure that is authorized by VOC as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the provider's contract's termination

Members and Participating Providers are encouraged to contact the VOC Clinical Referral Line to learn what options are available for continuing treatment after the transition period.

### **Obligation to Report/Duty to Warn**



reminder is sent informing the provider of the expiration date and the disenrollment process for failure to respond to said notice.

### **Returning from Absence**

Providers need to notify VOC that their absence from the network is ended and the date of return. When a provider indicates that they are reactivating network status, National Network Operations reviews the provider file, conducts PSV, and sends recommendation to the VOC Credentialing Committee. If the provider indicates that he or she would like to extend the leave of absence, the provider is asked to re-apply for network status and is recommended for disenrollment.

### **Confidentiality**

Providers agree to maintain the confidentiality of treatment and claims-related data concerning services provided to members in the normal course of business. Upon reasonable notice and during facility's regular business hours, VOC, its authorized representatives and duly authorized third parties (such as governments and payers) have the right to inspect and/or be given copies of medical records directly related to services rendered to members. Providers must ensure that each member's treatment record is treated as confidential so as to comply with all state and federal laws and regulations regarding the confidentiality of member records. Providers must cooperate with VOC and payer to ensure that all consents or authorizations to release member records are in conformity with applicable state and federal laws and regulations governing the release of records maintained in connection with mental health and/or substance abuse treatment. Providers must also ensure that any records meet all applicable federal and state laws and regulations related to the storage, transmission and maintenance of such records, including without limitation the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191) and the rules and regulations promulgated hereunder, as well as guidance issued by the United States Department of Health and Human Services.

### **Members Rights to Continue Course of Treatment When Provider Leaves the Network**

When a provider resigns or is disenrolled from the network, the provider must continue to provide covered services, at the rate and pursuant to the requirements specified in the Provider/Facility Agreement and to adhere to VOC' policies and procedures, to members receiving active treatment at the time of termination until the course of treatment is completed or until VOC makes reasonable and medically appropriate arrangements to have another provider render such services. Members and providers are encouraged to contact their benefit plan administrator or the VOC Clinical Referral Line to learn what options are available for continuing treatment after the transition period.

### **Compliance with National Provider Identifier (NPI)**

Effective May 23, 2007, all HIPAA transactions between VOC and a provider will require the use of NPI. See corresponding NPI section for definitions and NPI business rules.

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# Network Credentialing

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The VOC program for credentialing and recredentialing Providers is designed to comply with national accrediting organization standards as well as local, state and Federal laws. The program described below applies to VOC Participating Providers. The following is not intended to be an exhaustive list; VOC reserves the right to amend this list of standards.

## **Credentialing and Recredentialing**

All Providers who participate in VOC network must be credentialed/recruited according to VOC requirements. Among these requirements is primary source verification of the following information:

- Current, valid license to practice as an independent practitioner at the highest level certified or approved by the state for the Provider's specialty or facility/program status
- License current and valid and not encumbered by restrictions, including but not limited to probation, suspension and/or supervision and monitoring requirements
- Clinical privileges in good standing at the institution designated as the primary admitting facility, with no limitations placed on the practitioner's ability to independently practice in his/her specialty
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline or licensure
- Current Board certification, if indicated on the application
- A copy of a current DEA and CDS Certificate, as applicable
- No adverse professional liability claims which result in settlements or judgments paid by or on behalf of the practitioner which disclose an instance of, or pattern of, behavior which may endanger patients
- No exclusion or sanctions from government programs (i.e. Medicare/Medicaid)
- Current specialized training as required for practitioners

VOC also requires:

- Current, adequate malpractice insurance coverage
- An appropriate work history for the Provider's specialty
- No adverse record of failure to follow VOC policies, procedures or Quality Management activities. No adverse record of Provider actions that violate the terms of the Provider agreement
- No adverse record of indictment, arrest or conviction of any felony or any crime indicating patient endangerment
- No criminal charges filed relating to the Provider's ability to render services to patients
- No action or inaction taken by Provider that, in VOC sole discretion, results in a threat to the health or well-being of a patient or is not in the patient's best interest

Organizational Providers (facilities and programs) must be evaluated at credentialing and recredentialing. Those who are accredited by an accrediting body accepted by VOC (currently JCAHO, CARF, COA, AOA, AAAHC, CHAP and NCQA) must have their accreditation status verified. In addition, non-accredited organizational Providers must undergo a structured site visit to confirm that they meet VOC standards. Standing with state and federal authorities and programs will be verified.

### **Recredentialing**

VOC requires that practitioners and organizational Providers undergo recredentialing every three years.

Recredentialing will begin approximately six months prior to the expiration of the credentialing cycle. Providers are sent a recredentialing application that must be completed in its entirety, signed and returned to VOC as soon as possible, with all requested information attached. Failure to comply with our request may result in immediate disenrollment from the Provider network.

Credentialing information that is subject to change must be reverified from primary sources during the recredentialing process. The practitioner must attest to any limits on his/her ability to perform essential functions of the position and attest to absence of current illegal drug use.

A VOC provider who serves 50 or more unduplicated members within 24 months who relocates or opens an additional office since the previous credentialing decision must undergo a structured site visit review to ensure conformity with VOC standards. This review will include an evaluation against VOC site and operations standards and an evaluation of the practitioner's clinical record-keeping practices to ensure conformity with VOC standards.

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## CLAIMS PAYMENT

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### **Policies Regarding Network Provider Payment**

- Participating Providers will be reimbursed by VOC at the contracted or negotiated rate for covered services.
- Participating Providers will not be reimbursed for VOC benefit plan exclusions.
- A member can only be charged for the applicable account-specific co-payment portion of such rate for covered services.
- Members may not be charged for any fees or surcharge above the contracted rates.
- Participating Providers are not allowed to “balance-bill” patients. This includes any balance billing because a claim was denied for failure to obtain a required authorization for care, or for timely filing.
- The signature in Block 31 of the CMS-1500 Form certifies that services were actually rendered by the participating provider signing the claim form.

### **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 VOC web site at [www.valueoptions.com/providers](http://www.valueoptions.com/providers). In using this system, VOC and Participating Providers must:

- (i) Not change any definition, data condition or use of a data element or segment as proscribed in the 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)).

Participating Providers understand that there exists the possibility that VOC or others may request an exception from the uses of a standard in the HHS Transaction Standards. If this

occurs, Practitioner/Facility will participate in such test modification. Participating Providers understand that from time-to-time, HHS may modify and set compliance dates for HHS Transaction Standards. Participating Providers will comply with any such modifications or changes. VOC and its Participating Providers all agree to keep open code sets being processed or used for at least the current billing period or any appeal period, which ever is longer.

### **Prohibition of “Balance Billing”**

Participating Providers agree that in no event, including, but not limited to, nonpayment by ValueOptions of California, Inc, insolvency of VOC or breach of the provider/facility agreement with VOC, 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.

Participating Providers may not bill members for services to be paid for by VOC or for non-authorized services. This practice is known as “balance-billing.” Participating Providers who knowingly “balance bill” members are subject to provider sanctions. The network provider also agrees that this provision supersedes any oral or written contrary agreement previously entered into between the provider and member.

Participating Providers may only collect applicable co-payments from the member at the time of services. VOC will reimburse the network provider the balance up to the fee schedule maximum or negotiated rate or the billed charge (whichever is less) for covered services upon receipt of a clean claim form in compliance with VOC policies and procedures.

### **The following situations are *not* considered “balance-billing”:**

- Payments, full or partial, required for non-cancelled or missed appointments when the Member has given prior consent to such charges
- When Members contract with a Provider to self-pay for services not covered under their benefit plan.
- Billing Members who continue to have services provided after their yearly benefit maximums have been knowingly reached.

Note: In all of the above circumstances, providers are strongly encouraged to have such payment by members agreed to in writing by the member prior to the service being rendered and/or billed.

### **Non-Certified Services**

In the event that a Participating Provider fails to secure the required

authorization/certification from VOC for services that are included in the Member's plan, the Member shall not be held liable for the cost of the services. Participating Provider may bill the Member for services that are included in the Member's plan but that are not certified as medically necessary *only* if the provider has followed the procedures set forth in the Participating Provider's contract.

In the event that VOC notifies the Participating Provider that the proposed treatment or services for a Member will not be certified, or treatment or services for a Member which had been will no longer continue to be certified, the Participating Provider may initiate an appeal of such non-certification by following VOC appeal procedure. The Participating Provider must inform the Member of the VOC grievance/appeal process. If a Member wishes to continue to receive such non-certified treatment from the Participating Provider after the appeals process is completed and the non-certification decision was upheld, the Participating Provider must obtain the member's written consent to be financially responsible for any such non-certified treatment or services received from the Participating Provider thereafter. The member's consent must be in writing and signed and dated on or after the date that the appeals process is completed. Any prior agreement by a member to be financially responsible for non-certified treatment or services shall be null and void and the Participating Provider agrees that it will not attempt to enforce any such agreement.

### **Billing for Missed Appointments**

VOC does not authorize payment to Participating Providers for missed appointments, nor may a member be billed unless he or she has agreed in writing to pay out-of-pocket for any missed appointments at the start of treatment.

### **Diagnostic Evaluation**

A 90-minute diagnostic evaluation will be reimbursed only when the evaluation is done during the first session with a new Member.

### **Changes to your Provider Record**

To avoid a delay in reimbursement of submitted claims, you must notify VOC to update your records with changes to any of the demographic information below:

- You employ a billing service
- Primary mailing address changes
- Billing Address changes
- Practicing/Servicing Address Changes
- Name change(s)
- Employee Identification Number (EIN)
- Social Security Number (SSN)
- National Provider Identification (NPI)

Any changes to your Provider records must be submitted in writing to the *VOC* Provider Relations Department or to the address or fax below and by using the forms found at [www.valueoptions.com](http://www.valueoptions.com).

Mail

*ValueOptions Inc.*  
c/o Practitioner Maintenance  
P.O. Box 4080  
Virginia Beach, VA 23454

OR

Fax

757/412-6425 or 757/412-6592

To aid in expediting the submission of your claim for reimbursement, please submit the claim using your Participation Provider number and vendor combination received during the credentialing process.

- Your Provider number is your unique a six digit number (e.g. 123456) which identifies you as a contracted Provider.
- Your vendor number is a service location number where the service was rendered. You may have multiple vendor locations and each vendor location is given a five-digit number preceded by the letter 'A'. (e.g. A23456)

If you do not these numbers, contact the *VOC* Provider Relations Department or our national toll-free Provider Line at (800) 397-1630 during normal business hours Monday through Friday, eastern standard time (EST) for assistance.

### **Claim Submission Guidelines**

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

- Complete (“clean”) claims must be submitted on one of the two national industry standard billing forms:
  - Center for Medicare and Medicaid Services/CMS-1500 (formally known as HCFA-1500); or
  - Uniform Billing Form/UB-04 or HCFA-1450
- Completed claims forms may be mailed to: ValueOptions, P.O. Box 1290, Latham, NY 12110.

- A separate claim form, containing all required data elements, must be submitted for each Member for which the Participating Provider bills
- Limit each billing line to one date of service and one procedure code

### Claims Submission Tips

- **Coordination of Benefits (COB):** When VOC is coordinating benefits with another plan, the Explanation of Benefits (EOB) from the primary carrier must be submitted along with the paper claim to ensure timely and accurate payment.
- **Duplicate Claim:** VOC strives to have 100% of all claims processed within 30 days of receipt. If notification is not received within 30 days, please take the following steps prior to submitting a duplicate claim:
  - If the original claim was submitted as paper, wait 30 days from the date you submitted the claim before contacting VOC Customer Service to verify receipt and determine next steps. The Customer Service number can be located on the back of the member's identification card.
  - If the original claim was submitted as electronic, access the claim status inquiry through our online services at [www.valueoptions.com](http://www.valueoptions.com) to verify the claim was accepted.
  - When resubmitting a previously denied claim, please indicate on the claim that this is a resubmission. Please *do not add new services* that were not included on the original claim, these should be submitted separately.
- **Itemized bill is needed:** 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 HCFA claim forms (NO DATE SPANS).**
- **Valid DSM IV diagnosis codes**
- **Rendering provider and provider billing information, including tax identification number entered in appropriate areas of UB-04 and CMS1500 forms.**
- **Appropriate and valid place of service codes with correlating appropriate and valid CPT codes.**
- **Accurate member/patient information including member identification number,**

**patient name and DOB. Please do not use nicknames.**

- **Authorization and claim do not 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.

### **Claims Payment**

The use of scanning by means of Optical Character Recognition (OCR) technology allows for a more automated process of capturing information. This technology enables VOC to shorten turn-around time and improve quality. The following elements are required in order 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 from a processor 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 notes on 8 1/2" x 11" paper
- Use an 8-digit date format (e.g., 10212000)
- Use a fixed width font (Courier, for example)
- Use the patient's Date of Birth

### **Complete (Clean) Claims**

Participating Providers need to file claims for covered services in the form and manner required by VOC as specified below (herein referred to as a "complete claim"). Complete claims are to be *received* by VOC within 90 days from the date of service. A complete is a UB-04 or CMS-1500 (formally known as the HCFA-1500 claim form), or its successor, submitted by provider for medical care or health care services rendered to a covered member which accurately contains information including, but not limited to:

- Patient's name and date of birth
- covered Member's identification number


- date(s) and place of service or purchase
- services and supplies provided
- diagnosis narrative or ICD-9 code
- procedure narrative or CPT-4 code
- provider's name, address and tax identification number
- provider's license number
- provider's charges
- other information or attachments that may be mutually agreed upon by the parties in writing

If additional information is required, the Participating Provider agrees to cooperate by providing any information reasonably requested for the purpose of consideration and in obtaining necessary information relating to coordination of benefits, subrogation, and verification of coverage and health status. All billings by the Participating Provider will be considered final unless a Provider Dispute request is received within 365 days from the date indicated on the Explanation of Benefits form sent by VOC. Reimbursement is based upon certification for services covered under the Member's benefit plan and the Member's eligibility at the time of service.

**Note:** In California there are extensive rules and regulations that pertain to the processing of claims by health care service plans which apply to VOC and its Participating as well as Non-Participating Providers. These additional claims processing requirements and Provider Dispute guidelines are described in VOC's policies and procedures. You can obtain a copy of these policies by contacting the Provider Relations Department.

### **Electronic Submission**

Participating Providers may elect to file claims electronically, and are in fact encouraged to do so. VOC's Online Provider Services are designed to give providers easy access to eligibility inquiry, claims status inquiry and electronic claims. These services are provided at no cost. Submitting claims electronically improves accuracy, increases the speed of claim payment and reduces your administrative office costs.

 **Note:** If you submit electronic claims to VOC, please note that as of October 16, 2003 VOC will only accept claims transactions in standard HIPAA 837 format, as delineated by the Health Insurance Portability and Accountability Act (HIPAA). To obtain further information access our website [www.valueoptions.com/eProvider/providers.jsp](http://www.valueoptions.com/eProvider/providers.jsp) and proceed to review the HIPAA section.

### **Filing Requirements for Claims**

#### **Timeliness**

VOC must receive claims from Participating Providers for all services rendered within 90 calendar days from the date of service or date of discharge. Participating Providers are prohibited from billing members for such services. VOC will not be responsible for payment of claims for covered services not received within ninety (90) calendar days of the rendering of such services, unless the provider can demonstrate good cause for such delay, as determined in accordance with the VOC provider dispute resolution mechanism.

### **Contested (Incomplete) Claims Are Not Clean Claims**

Claims will be returned to the Participating Provider due to invalid or incomplete information. All contested claims received with incomplete information will be returned with an Explanation of Benefits advising the provider of the incorrect or invalid information. A “corrected” claim should be sent to VOC providing the updated information for reconsideration.

If VOC is unable to locate a Member’s ID number provided on the claim form, the claim will be returned with an Explanation of Benefits indicating the member is unknown. We will indicate the member’s name in the patient account number field, shown on your Explanation of Benefits. Any changes should be made and a new claim sent for consideration. Please be sure to send all requested information within the VOC timely filing guidelines (call the toll-free number on the back of the Member’s ID card for pertinent details.)

### **Coordination of Benefits Payment Methodologies**

One of the primary reasons for delays in claims processing is the lack of information necessary to coordinate benefits across multiple payers. The following tips are designed to assist you in reducing payment delays attributed to coordination of benefits related issues.

- Ask each Member if they have coverage through multiple payers.
- If the Member does not have other coverage and the services are being submitted on a CMS 1500, please make sure that 11 (d) indicates “NO”. If other coverage is available, the other insured information in box 9 (a-d) needs to be completed.
- Determine the primary and secondary payers.
- Attach the Explanation of Benefits from the primary payer when submitting the claim as secondary.

A “**guide**” to determine how claims should reimburse:

### **Non-Medicare**

- **Carve-out formula:** VOC fee schedule – Patient liabilities – Primary payment = VOC payment

- **Maintenance of benefits formula:** VOC fee schedule – Primary payment = VOC payment

### **Medicare**

- **Traditional/standard formula:** Charges – Medicare payment = VOC payment
- **Carve-out formula:** VOC fee schedule OR Medicare allowed amount (whichever is less) – Medicare payment = VOC payment

**Note: There are slight variances to these formulas for Medicare “assigned” and “unassigned” providers.**

**Exclusion method formula:** VOC fee schedule – Medicare payment – VOC patient liabilities = VOC payment

### **Third Party Liability/Coordination of Benefits**

Participating Providers agree to cooperate with VOC in providing any information reasonably requested in connection with claims and in obtaining necessary information relating to the coordination of benefits. The provider agrees to make reasonable efforts to determine whether Members have insurance or other health care coverage other than VOC and will promptly report any duplicate coverage to VOC. The Participating Provider understands and agrees that the coordination of benefit rules of the applicable Client plan will determine payment made to the provider and that, in no event, shall the Client be obligated to pay the provider any portion of a secondary payment whereby the sum of the primary payment plus the secondary payment exceeds the compensation specified in the Reimbursement Schedule.

- The provider must exhaust all avenues of other insurance coverage and payment prior to billing for covered services.
- When the primary insurance carrier has made a decision regarding reimbursement, a copy of the disposition (EOB) must accompany the CMS-1500 or UB-04 claim submission to VOC to ensure accurate coordination of benefits payment.
- All timely filing rules are applied and enforced from the date of the primary insurance carrier’s disposition.
- Coordination of Benefits Payment Methodologies vary by contract.

### **Nursing Home Services**

Services rendered in a nursing home setting are considered to be outpatient rather than inpatient. It is important to ensure that the billed service code represents an outpatient service. For further assistance, contact our Clinical Management or Customer Service Team.

### **SMI/SED Plan Services**

ValueOptions of California may contract directly with a Client group to provide covered services for certain behavioral health conditions on the same terms and conditions (“parity”) as with the Client’s medical plan. The “parity” plan includes Covered Services provided for Mental Disorders which include Severe Mental Illnesses (“SMI”) of a person of any age and Serious Emotional Disturbances (“SED”) of a minor child under the age of eighteen (18) years. Participating Providers agree to render Covered Services, including those services for treatment of SMI and SED, in accordance with all applicable terms and conditions set forth in the Behavioral Services Agreement entered into by and between ValueOptions of California and a Client. Co-payments, out-of-pocket maximums, benefit and lifetime maximums for SMI/SED services are subject to the same requirements and provisions as in effect for a member’s medical and hospital plan.

### **Provider Disputes - Claim Appeals and Grievances**

A network provider has the right to dispute VOC claims determination. Provider disputes for an individual claim, billing dispute, or other contractual dispute, or disputes related to demonstrable and unfair Plan payment patterns must be submitted in writing and received by VOC within 365 days from the date of the Plan action (or the most recent Plan action if there are multiple actions) that led to the dispute. (Example: A disputed claim decision must be submitted within 365 days from the date on the VOC’s Explanation of Benefits.)

The Provider Dispute guidelines are described in VOC’s policies and procedures. You can obtain a copy of the Provider Dispute policy by contacting the Provider Relations Department or by accessing our list of policies and procedures at our web site at [www.valueoptions.com](http://www.valueoptions.com).

### **ERISA Claims Rules and Procedures**

On July 1, 2002, new federal regulations for claims and appeals for employer-sponsored health plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) went into effect. For more information regarding how these rules affect the filing of claims and appeal of denied claims, please contact your VOC Provider Relations Office or call (800) 397-1630.

### Attachments

Example of MHS Voucher and Tip Sheet

#### Sample EOB/Summary Voucher for Providers

#### CHECK PAGE

PROFILE: S13	CHECK #: 003328
DATE: 06/01/98	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 00 CENTS**

TO THE ORDER OF

COMPANY NAME  
 ADDRESS  
 CITY, ST ZIP CODE

\_\_\_\_\_  
 AUTHORIZED SIGNATURE

PROVIDER SUMMARY VOUCHER PAGE 1

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

**A**

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

**B**

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

**C**

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

**PROVIDER NUMBER:**

DATE OF	PROC MOD	UNITS	CHARGED	ALLOWED	PROVIDER	DISCOUNT	COB	PREPAID	NON-	COVRD	DEDUCTIBLE
CO-PAY	CO-INS	AMOUNT	OTHER	EOP							
SERVICE	CODE	COD	AMOUNT	AMOUNT	WITHHOLD	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT
AMOUNT	PAID	INS	CODES								

**D**

<b>PATIENT: John Doe 1</b>			<b>MEMBER #: P67250301</b>				<b>PATIENT #: 2808661</b>			<b>PARENT/GROUP: COM 555555 CLAIM #:01 091667 20133</b>		
<b>00002</b>												
0407-040798	90844	3	5.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
0413-041398	90844	1	95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
CLAIM TOTAL:			190.00	93.00	0.00	0.00	0.00	0.00	0.00	0.00	93.00	
<b>PATIENT: John Doe 2</b>			<b>MEMBER #: K01326DD1</b>				<b>PATIENT #: 2808022</b>			<b>PARENT/GROUP: COM 555555 CLAIM #:01 091667 20132</b>		
<b>00002</b>												
0402-040298	90844	1	95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
0407-040798	90844	1	95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
0412-041298	90844	1	95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
0415-041598	90844	1	95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
0422-042298	90844	1	95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
0427-042798	90844	1	95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
CLAIM TOTAL:			70.00	279.00	0.00	0.00	0.00	0.00	0.00	0.00	279.00	
<b>PATIENT: Jane Doe 1</b>			<b>MEMBER #: K01327301</b>				<b>PATIENT #: 2808541</b>			<b>PARENT/GROUP: COM 555555 CLAIM #:01 091667 20131</b>		
<b>00003</b>												
0402-040298	90844	1	95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
0407-040798	90844	1	95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
0412-041298	90844	1	95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
0415-041598	90844	1	95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
0422-042298	90844	1	95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
0427-042798	90844	1	95.00	46.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
CLAIM TOTAL:			570.00	279.00	0.00	0.00	0.00	0.00	0.00	0.00	279.00	
<b>PATIENT: Jane Doe 2</b>			<b>MEMBER #: K01326701</b>				<b>PATIENT #: 2808141</b>			<b>PARENT/GROUP: COM 555555 CLAIM #:01 091667 20129</b>		
<b>00001</b>												
0405-040598	UNK	1	95.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
CLAIM TOTAL:			95.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
<b>PATIENT: John Doe 3</b>			<b>MEMBER #: 57380667503</b>				<b>PATIENT #: 9704601</b>			<b>PARENT/GROUP: COM 555555 CLAIM #:01 120467 04905</b>		
<b>00002</b>												
0315-031598	90844	1	95.00	63.25	0.00	0.00	0.00	3.25	0.00	10.00	0.00	



# VALUE OPTIONS

## Provider Handbook

0315-031598 90844	1	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
<b>PATIENT: Jane Doe 3</b>		<b>MEMBER #: 05062806501</b>			<b>PATIENT #: 3652145</b>			<b>PARENT/GROUP: COM 555555 CLAIM #:01 110795 22237</b>					
<b>00003</b>													
0401-040198 90801	1	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	1	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	1	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	1	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

**TOTAL PAID FOR THIS PROVIDER: 385.00**

**THIS SPACE IS RESERVED FOR A GENERAL COMMENT.**

**E**

Provider Summary Voucher Key

	<b>Field</b>	<b>Description</b>
<b>A</b>	COMPANY NAME	The Service Center specific address and telephone number to direct customer service related questions and correspondences.
<b>B</b>	PROVIDER INFORMATION	The provider's billing location name and address.
<b>C</b>	PARENT/GROUP	Internal codes that define the client associated with the patient.
<b>D</b>	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. UNITS	Indicates the number of services provided for the service dates billed. Units can be measured in days, hours or increments of hours, based on the service provided.
	5. CHARGED AMOUNT	The amount billed by the provider for the service rendered.
	6. ALLOWED AMOUNT	The client's allowed amount for the service rendered.
	7. PROVIDER WITHHOLD	A contractual amount withheld from the provider's payment which should not be billed to the patient.
	8. DISCOUNT AMOUNT	A negotiated amount with the provider indicating the payment will be reduced by an agreed upon percentage.
	9. COB	The amount recovered as the result of not being the primary payer of benefits.
	10. PREPAID AMOUNT	The amount paid to the provider prior to the service being rendered.
	11. NON-COVRD AMOUNT	Non-Covered - The amount not covered
	12. DEDUCTIBLE AMOUNT	The amount applied to the deductible.
	13. CO-PAY AMOUNT	A fixed dollar amount due to the provider from the patient.
	14. CO-INS	Co-Insurance - A percentage of the allowed amount due to the provider from the patient.
	15. AMOUNT PAID	The amount paid by our company on the claim.

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	16. OTHER INS	Other Insurance - The amount paid by the primary insurance carrier.
	17. EOP CODES	The explanation of payment code(s).
<b>E</b>	MESSAGE AREA	Customized message area.

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## **CLAIMS BILLING AUDITS**

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ValueOptions, Inc., the parent company of VOC, pays for mental health services for millions of beneficiaries and makes payments to tens of thousands of mental health providers. As such, this provides ample potential for improper billing whether erroneous or fraudulent in nature.

ValueOptions, Inc. has a department, the Special Investigations Unit (or SIU) responsible for reviewing and monitoring claims and billings by providers to ensure payment has been properly requested and made. The SIU works with VOC to review and monitor provider claims and billings.

ValueOptions, Inc. has four primary lines of business: Employer Solutions (Employer groups) (VOC is in the Employer Solutions Division), Health Plan Division (Public and Private Groups, Medicare, and Medicaid), Public sector (Medicaid) and Federal Services (Tricare). All of these are subject to scrutiny by *ValueOptions, Inc.*'s SIU as well as regulatory authorities responsible for monitoring health insurance fraud and abuse activity. Provisions in both the Balanced Budget Act of 1997 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) make it very evident that federal lawmakers are intent on addressing issues of fraud and abuse. Within the industry the Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services Offices of the Inspector General (HHS-OIG), the FBI, and the United States Attorney's Offices, have joined forces to administer a comprehensive anti-fraud program. In addition state insurance laws and enforcement authorities have focused considerable effort on improper billing and fraud.

*ValueOptions, Inc.* and VOC thus has both legal and fiduciary obligations to ensure that the funds they receive from clients, including federal and state government funding, is properly paid for services rendered by providers. The SIU of *ValueOptions, Inc.* is charged with this responsibility on behalf of VOC and its clients.

### ***Billing & Audit Process***

The SIU monitors and investigates potential cases of improper billing and fraud. The SIU identifies potential cases through a variety of means: (i) patient inquiry or complaint; (ii) external referral from state, federal and other regulatory agencies (iii) internal staff inquiry, (iv) data analysis of certain statistical anomalies and (v) whistleblowers. Not every case identified as potential improper billing results in actual findings of improper billing or fraud. The SIU and VOC investigate any potential case thoroughly before making any conclusions and taking any action.

*The SIU and VOC* conducts audits in two ways: (1) record review audit and (2) on-site audit. The SIU conducts the majority of its audits through record review audits. This entails requesting a sample of records from the provider to compare against claims submission records. The initial sample size is normally between five (5) and ten (10) patient files depending on the

issues identified and the number of *VOC* members treated by the provider, however *VOC* reserves the right to request a sample up to and including all identified *VOC* members. (The provision of these files for audit purposes is a requirement of the participating provider contract.) Failure to supply requested documentation or cooperate with the SIU Investigation could result in disciplinary action for breach of the provider contract. Clinical files pertaining to *VOC* members should be maintained for the time period detailed in your practitioner agreement.

Providers must supply copies of requested records to *VOC* within five (5) working days. *VOC* will treat your records confidentially. Records are reviewed by the Special Investigations Unit, and as necessary with consultation of appropriate members of the *VOC* Clinical and Quality Teams. These records are compared against the claims submissions to verify the accuracy of the claims submissions. The SIU and *VOC* complete a review of the records and reports the findings to the provider in writing.

### ***Notification of Findings***

In the event that improper or fraudulent billings are identified *VOC* and the SIU sends a detailed written report detailing findings including a required Action Plan with specific recommendations. These recommendations may include but are not limited to:

- **Provider Education**- Working with our Provider Relations team, the SIU department develops an educational program that will review the deficiencies identified, and provide tools to assist the provider in correcting these concerns and work towards full compliance with *VOC* requirements as well as state and federal regulations as applicable.
- **Corrective Action Plan**- *VOC* may require that the provider submit a Corrective Action Plan (CAP) clearly identifying steps the provider will take to meet *VOC* standards and correct all identified deficiencies. Within this CAP, the provider will detail his understanding of our findings, willingness to carry out all recommendations by *VOC*, and a timeframe that all changes will be completed. Generally, a provider is allowed up to thirty (30) days to complete this requirement.
- **Repayment of Claims Funds**- *VOC* may include a request for repayment within this communication. This dollar amount is calculated based on *VOC*'s total payment as of the completion of this audit against the findings detailed in an Excel spreadsheet format. A provider has the right to dispute *VOC*'s determination. The Provider Dispute guidelines are described in *VOC*'s policies and procedures. You can obtain a copy of the Provider Dispute policy by contacting the Provider Relations Department.
- **Monitoring**- *VOC* may require additional Monitoring of claims submissions and treatment record standards for a period of six (6) to twelve (12) months.

### ***Provider Non-compliance***

VOC respects its partnership with its network providers and will work with their providers in an effort to handle SIU cases. Failure to comply with Corrective Action Plans may result in the following, as appropriate:

- Network Termination- When issues of abusive or inappropriate billings are not resolved by our network providers, VOC will recommend to the VOC Credentialing Committee immediate termination of said provider from our networks.
- State and/or Federal Referral- VOC will report any suspicion or knowledge of fraud and/or abuse that requires an external investigation to the appropriate authorities. VOC will cooperate fully in any investigation or subsequent legal action that may result from such an investigation. VOC and its providers are required to make available to investigators any administrative, financial, and medical records such investigators may require.

Fighting fraud and abuse strengthens and preserves VOC” services to providers and Members and enhances the health care delivery system as a whole.

### ***Abuse or Inappropriate Billing Examples***

VOC defines abuse as any practice, direct or indirect, that is inconsistent with sound or established fiscal, business, insurance, or medical practices and results in an unnecessary cost to a behavioral health benefits program. It also consists of reimbursement for services performed that are not medically necessary or that fail to meet professionally recognized standards for health care. A provider may or may not have knowingly and/or intentionally misrepresented facts to obtain payment. Abuse also includes any practices by a member that results in unnecessary costs to a behavioral health program.

Abusive billing or practices involve payments for services or items when there is no legal entitlement to that payment even though the provider did not intentionally misrepresent facts to obtain payment. Under certain circumstances abuse may constitute or evolve into fraud. Here are some examples of abuse:

- Inappropriate balance billing;
- Inadequate resolution of overpayments;
- Lack of integrity in computer systems;
- Failure to maintain confidentiality of information/records;
- High utilization of procedures or tests not medically necessary;

- Providing services that are not medically necessary;
- Providing poor quality medical services;
- Unbundling/exploding charges (e.g., the unpacking and billing separately of services that would ordinarily be all-inclusive);
- Coding a service at a higher level than what was rendered (i.e. up coding);
- Violation of practitioner participation agreement by provider;
- Breaches of practitioner agreement that result in members being billed for amounts not allowed by *VOC*;
- Failure to collect coinsurance and deductible amounts;
- Excessive charges for services;
- Inappropriate documentation of services rendered.

### ***Fraud Examples***

Some of the more common forms of fraud include:

- Submitting claims for services that were not provided. This includes billing for “no shows” or canceled appointments (i.e. billing *VOC* for services which were not actually rendered because the patients failed to keep their appointments). Note: If appropriate documentation is on file (patient agreed in writing prior to start of treatment), the patient may be billed directly for a “no show” or canceled appointment;
- Misrepresenting the diagnosis for the patient in order to justify payment;
- Utilizing split billing schemes (i.e., billing procedures over a period of days when all treatment occurred during one visit);
- Altering a claim form to obtain a higher payment amount;
- Soliciting, offering, or receiving a kickback, bribe, or rebate (i.e., paying for a referral of patients in exchange for ordering of diagnostic tests, other services, or supplies);
- Duplicate billing in an attempt to gain duplicate payment (e.g. this can involve billing multiple claims to *VOC* or billing a claim to both *VOC* and another insurer in an attempt to gain duplicate payments);
- Billing for a service not furnished as billed;
- Participating in schemes that involve collusion between a provider and a member;
- Billing for non-covered services as covered services (CPT codes);
- Billing based on “gang visits” (i.e., a provider visits a nursing home and bills for 20 nursing home visits without furnishing any specific service to, or on behalf of, individual patients);
- Knowing misuse of provider identification numbers that results in improper billing;

- False or fraudulent filings of claims;
- Misrepresenting the service rendered, place of service, date of service, etc.;
- The acceptance of, or failure to return, monies allowed or paid on claims known to be false or fraudulent;
- Intentionally failing to provide needed medical services;
- Falsifying certificates of medical necessity, plans of treatment, and medical records to justify payment.
- Billing for services by a provider for services actually rendered by an affiliated (i.e. employed or associated with same group etc.) provider who is not a contracted or credentialed provider of VOC

***Responsible Parties***

Perpetrators may include, but are not be limited to, a practitioner; a hospital, an agency, an organization, or other institutional provider; an employee of a provider; a billing service; or any person in a position to file a claim for behavioral health benefits.

***Documentation Standards***

Claims must be supported by adequate documentation of the treatment services rendered. VOC defines treatment record standards under **Section I: Administrative Section, “Participating Provider Responsibilities”** of this same manual. Strict adherence to these guidelines is required. A patient’s medical record must contain documentation to substantiate the billed services. The lack of documentation will result in denial of benefits, or, if payment has already been issued, recovery of payment.

***Waiving Patient Responsibilities***

<b>Co-payment</b>	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 co-payments.
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Waiving a co-payment if the patient's benefit’s requires one, changes the fee. If you file a claim listing your usual and customary fee of \$100.00, but you plan to waive the \$20.00 co-payment, your fee is really only \$80.00, in the view of the health plan. Accordingly, the provider has misstated the fee to the health plan, and that misrepresentation can constitute either fraud or a false statement within the meaning of the Portability Act.

Network providers must collect applicable co-payments from the member at the time of services. VOC will reimburse the network provider the balance up to the fee schedule maximum or negotiated rate or the billed charge (whichever is less) for covered services upon receipt of a completed claim form in compliance with VOC's policies and procedures.

### ***Eliminating Fraud and Abuse***

To eliminate fraud and abuse successfully, providers, facilities, and members must work together to prevent and identify inappropriate and potentially fraudulent billings. This can only occur by:

- Monitoring claims submitted for compliance with billing guidelines;
- Adherence by providers and facilities to Treatment Record Standards;
- Education of all staff members responsible for dealing with medical records (including documentation, storage, retrieval, or review) or who are involved with billing;
- Referring cases of suspected fraud and abuse.

### ***Reporting Fraud and Abuse***

Reports of fraud and abuse, or suspicions thereof, can be made in any of the following formats:

- Written responses can be sent to:

VOC  
Claims Liaison / SIU Coordinator  
P.O. Box 6065  
Cypress, CA 90630

or

*ValueOptions, Inc.*  
Corporate Headquarters  
ATTN: Special Investigations Unit  
240 Corporate Blvd.  
Norfolk, VA 23502

- Telephonic contacts can be directed to our Ethics Hotline:

1 (888) 293-3027