

PARTICIPATING PROVIDER RESPONSIBILITIES

In order to provide quality services to members, it is necessary for ValueOptions® of California and its providers to maintain a collaborative relationship. We strongly believe in the concept of "partnership" with those who deliver service to ValueOptions® of California members. To maintain open communication, we encourage you to direct questions and concerns to the ValueOptions® of California Provider Relations Department. **Members must be excluded from any dispute between the provider and ValueOptions® of California.**

ValueOptions® of California has a Provider Relations team ready to assist you. In addition, the ValueOptions® toll-free National Provider Line can help you with many issues. Simply call **(800) 397-1630**, Monday through Friday, between 8:00 AM and 5:00 PM Eastern Standard Time (EST).

Changes to your Provider Record

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

- You employ a billing service or change billing services
- Primary mailing address changes
- Billing address changes
- Practice/service address changes
- Phone/Fax/Email changes
- Name change(s)
- Employee Identification Number (EIN)
- Social Security Number (SSN) or Tax Identification Number (TIN)
- National Provider Identifier (NPI)
- Practice panel status (open/closed)
- Provide status with group/facility

Any changes to your provider record must be submitted in writing to the address or fax number below and by using the *Change of Address* form and *W-9 Substitute* form found at www.valueoptions.com. ValueOptions® of California encourages providers to utilize ProviderConnect to make changes to provider file information.

Mail: ValueOptions®, Inc.
C/o Practitioner Maintenance
P.O. Box 41055
Norfolk, VA 23541

OR

Fax: (866) 612-7795

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

HIPAA 837 Billing Instructions for Providers

When using software other than EDI Claims Link for Windows:

LOOP 2010AA – Billing Provider Information

NM1*85 (85 indicates this is the billing provider information and is the only valid value)	NM108 = XX (XX indicates this is NPI data)	NM109 = Agency's NPI (Your billing NPI number)	The agency's NPI is required so that a valid match can be made against the information which you submitted to ValueOptions®.
N3			This should be the billing address for the agency (the location to which vouchers/checks will be mailed). The address should match the address on the summary vouchers sent to you by ValueOptions®.
N4			City, State Zip for the preceding address.
REF	REF01 = EI	REF02 = Agency Tax ID	Tax ID information is required for tax purposes.

Service Location must include the address where services were rendered. Although the XX qualifier is not required in this loop, if you do enter the XX qualifier you must include the Agency NPI number in the NM109 field.

LOOP 2310D – Service Facility Location

NM1*FA	NM108 = XX This is not required, but if it is supplied, the value MUST be "XX"	NM109 = Agency NPI This is not required, but if it is supplied, the value MUST be the agency NPI	Only the Agency NPI is a valid value. Tax ID or SSN values which might have been carried in this segment are no longer options
N3			This should be the address where services for this claim

			were rendered.
N4			City, State Zip for the preceding address.

Rendering Provider must include the Agency NPI, XX qualifier, and taxonomy code:
LOOP 2310B – Rendering Provider

NM1*82	NM103 – Rendering practitioner’s last name followed by a comma, followed by one space, then the licensure level		This information is required to determine which fee schedule should be applied for the professional services contained on the claim. EXAMPLE: Smith, LCSW
NM1*82	NM108 = XX Since NPI is mandatory, the value MUST be “XX”	NM109 = Agency’s NPI	
PRV	PRV02 = ZZ	PRV03 = Taxonomy for the rendering practitioner	

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 ValueOptions® of California shall not be construed as a directive from ValueOptions® of California 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 ValueOptions® of California or payers in no way absolve a provider of responsibility to render appropriate services. If services are rendered with an out-of-network provider or at an out-of-network facility, this may result in higher out-of-pocket expenses for the member.

Providers must:

- Verify member eligibility and benefits prior to rendering services.
- Preauthorize care when required, prior to rendering services.
- Verify coverage with ValueOptions® of California 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 ValueOptions® of California network.
- Adhere to the accessibility and availability standards established by ValueOptions® of California.
- Ensure equal treatment of all ValueOptions® of California members, regardless of product.
- Ensure ValueOptions® of California has the most current practice/facility information as it relates to contract agreement.
- Notify ValueOptions® of California of potential inpatient discharge problems.
- Advise members of financial responsibility regarding services that are not covered, prior to rendering such service.
- Notify ValueOptions® of California 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 ValueOptions® of California, submit copies of member medical records without charge.

Professional Standards

Providers must render covered services in a quality and cost-effective manner recognizing ValueOptions[®] of California 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

ValueOptions[®] of California 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 ValueOptions[®] of California 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 needs 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 ValueOptions[®] of California, insolvency of ValueOptions[®] of California or breach of the provider/facility agreement with ValueOptions[®] of California, 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 ValueOptions[®] of California or for non-authorized services. This practice is known as “balance-billing.” Providers who knowingly “balance bill” members, are subject to provider sanctions. The provider also agrees that this provision supersedes any oral or written 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. ValueOptions[®] of California 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 ValueOptions[®] of California policies and procedures. Coordination of benefits and deductibles vary by contract. ValueOptions[®] of California will not reimburse a provider if a service is a non-credentialed and/or non-contracted covered benefit. A provider may request reimbursement from an existing ValueOptions[®] of California 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.

In the event that ValueOptions® of California notifies a provider that: (i) proposed treatment or services for a member will not be certified; or (ii) treatment or services for a member which had previously been certified will no longer continue to be certified, the provider may initiate an appeal of such non-certification by following ValueOptions® of California appeals procedure as specified in the Provider Handbook. The provider must inform the member of the ValueOptions® of California appeals process. At the time of the first denial, the provider may inform the member of the denial and seek written consent from the member to be financially responsible for the non-certified treatment. However, the provider must continue and complete the appeals process in good faith before billing the member directly for non-certified services.

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. 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 the Credentialing or Recredentialing Process

ValueOptions® of California providers are required to report material changes to information that was submitted to ValueOptions® of California as part of the credentialing or recredentialing process to the ValueOptions® National Provider Line at (800) 397-1630 from 8:00 a.m. – 5 p.m. Eastern Standard Time (EST). **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 material changes to information that was submitted for:

- Any action against any of its licenses and/or accreditation by JCAHO, CARF, AOA, COA or any successor thereof.
- Any changes in ownership or business address.

- Any legal or government action initiated that could materially affect the rendering of services in connection with this agreement.
- Any legal action commenced by or on behalf of a ValueOptions® of California member against provider.
- Any initiation of bankruptcy or insolvency proceedings with regard to provider, whether voluntary or involuntary.
- Any other occurrence known to provider that could materially affect the rendering of services in connection with the provider agreement.
- 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).
- Expiration of required professional liability insurance coverage (must be reported within thirty (30) calendar days prior to the expiration of such coverage).
- 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, etc.
- 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 ValueOptions® of California within 24 hours all “adverse incidents” involving ValueOptions® of California members. Adverse incidents are defined as “occurrences that represent actual or potential serious harm to the well being of a ValueOptions® of California member or to others by the actions of a ValueOptions® of California member who is in active behavioral health treatment/EAP services that is being managed by ValueOptions® of California, or has been recently discharged (i.e. within the past 12 months) from behavioral health treatment/EAP services managed by ValueOptions® of California.” All adverse incidents must be reported 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 ValueOptions® of California 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); and/or
- 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, ValueOptions® of California 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 ValueOptions® of California 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

ValueOptions® of California, 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. ValueOptions® of California 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 Emergency

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 48 hours of the request.

Routine

In a routine situation, a member must be offered the opportunity to be seen within ten (10) business days of the request for an appointment for Mental Health Substance Abuse services and within seven (7) calendar days of the request for an appointment for EAP services.

Rescheduling an Appointment

When it is necessary for a provider or member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the member's health care needs, and ensures continuity of care consistent with good provider practice.

Cultural Competency

ValueOptions[®] of California 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. ValueOptions[®] of California 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 ValueOptions® Cultural Competency Committee. The ValueOptions® Cultural Competency Committee meets quarterly and includes representatives from ValueOptions®, Inc. departments of utilization management/clinical services, provider relations, information systems, customer service, marketing/sales and quality management. The ValueOptions® Cultural Competency Committee is responsible for building and maintaining ValueOptions® of California's commitment to cultural competency.

Coordination of Care

ValueOptions® of California recognizes the importance of integrating the delivery of behavioral and physical health services to a given member. To that end, you are required 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.

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 ValueOptions® of California. **Provider participation in random treatment record audits is an integral part of ValueOptions® of California's quality management program and is a condition of network participation.**

ValueOptions® of California 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.

ValueOptions[®] of California will gain access to treatment records by reviewing them at your office, or requesting that photocopied records be forwarded to ValueOptions[®] of California. Providers will not be reimbursed for copies of medical records requested by ValueOptions[®] of California. Providers must supply copies of requested records to ValueOptions[®] of California within five (5) business days of the request. ValueOptions[®] of California 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 ValueOptions[®] of California 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 ValueOptions[®] of California 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 ValueOptions[®] of California standards for treatment records.

For the purpose of conducting retrospective case reviews, clinical files pertaining to 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 ValueOptions[®] of California and accrediting bodies. ValueOptions[®] of California adheres to standards of accrediting organizations such as the National Committee for Quality Assurance (NCQA), the American Accreditation Healthcare 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 ValueOptions[®] of California's accreditation process or regulatory review, and are also subject to random audits by ValueOptions[®] of California Quality Management Department.

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 ValueOptions® of California'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 in the record of coordination of care with the PCP or declination of this coordination by the member.
25. The treatment record has evidence of continuity and coordination of care between behavioral healthcare institutions, ancillary providers and or consultants.
26. The treatment record reflects evidence of coordination of care with other outpatient behavioral health practitioners.
27. 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, and 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 ValueOptions® of California for individual psychotherapy with medical evaluation and management services (e.g. 90805 and 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, and 90808), the actual time spent must clearly be documented within the member's record. This time should be documented indicating a session's start and stop times (e.g. 9:00 a.m. – 9:50 a.m.).

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.

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.

ValueOptions® of California does apply a 45 to 50 minute guideline to family therapy codes.

Site Visits for Quality Reviews

ValueOptions® of California 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

- All non-accredited facilities/organizational providers prior to the initial credentialing decision and every three (3) 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 or opens an additional site

Quality

- All network practitioners with two or more documented member complaints in a six month time frame relating to physical accessibility, physical appearance, adequacy of waiting/examination room space, availability of appointments, and/or adequacy of treatment record keeping.
- When a quality of care concern indicates that a site visit may assist in the resolution of the identified facility/organizational provider or practitioner quality of care issue.

You will be contacted by ValueOptions® of California 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 ValueOptions® of California standards.

The instrument currently applied during the site visit is continuously under study and ValueOptions[®] of California reserves the right to alter it as needed. (Please visit www.valueoptions.com for applicable site visit forms.)

Requirement to Respond to ValueOptions[®] of California Inquiries

ValueOptions[®] of California 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 ValueOptions[®] of California Quality Improvement and Utilization Management Programs

ValueOptions[®] of California 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 ValueOptions[®] of California 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 ValueOptions[®] of California quality management and utilization management programs and is a condition of network participation. Per your provider agreement, you must cooperate and comply with ValueOptions[®] of California quality, claims/billing and utilization management activities and standards.

Member Rights and Responsibilities

It is the policy of ValueOptions[®] of California to ensure that members are treated in a manner that respects their rights and responsibilities as members. Providers are required to inform ValueOptions[®] of California members under their care of these rights and responsibilities. The ValueOptions[®] of California 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 ValueOptions[®] of California Web site at www.valueoptions.com for posting.

Member Right to Continuing 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 ValueOptions[®] of California Provider/Facility Agreement and to adhere to ValueOptions[®] of California policies and procedures, to members receiving active treatment at the time of

termination until the course of treatment is completed or until ValueOptions[®] of California makes reasonable and medically appropriate arrangements to have another provider render such services.

Special Circumstances Continuing Care Obligations

Following the termination of the ValueOptions[®] of California Provider/Facility Agreement for reasons other than medical disciplinary cause or reason, fraud or other criminal activity, the provider shall, at the request of the applicable member and in accordance with ValueOptions[®] of California 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 ValueOptions[®] of California or participating providers to cover services or provide benefits that are not otherwise covered under the terms and conditions of the member's ValueOptions[®] of California 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 ValueOptions[®] of California in consultation with the member and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (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 twelve (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 ValueOptions[®] of California as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 calendar days of the provider's contract termination

Members and providers are encouraged to contact the ValueOptions® of California Clinical Referral Line to learn what options are available for continuing treatment after the transition period.

Obligation to Report/Duty to Warn

Providers must comply with all applicable state and Federal child/elder abuse and other reporting laws. It is your responsibility to understand and comply with the professional and legal requirements within California.

The duty to warn a potential victim of possible harm from a member may override the usual right to confidentiality of which an individual is assured when speaking to a clinician. This applies to any provider who receives information during assessment or treatment. In any threatening situation, relevant clinical data or history may be released to authorities. If you believe that a member represents a threat to self or others, you may be required to attempt to protect the member and to warn the potential victim(s) in a timely manner. It is preferable to contact the police, but you should warn the intended victim by telephone if that is the best way to assure the potential victim's safety. It is your responsibility to be thoroughly familiar with the duty-to-warn rules of California. ValueOptions® of California should also be made aware of any such situation. ValueOptions® of California may contact you when we are notified first of a potential situation. You will be called upon to exercise your duty-to-warn obligations in such a situation. Report all potential situations to the Clinical Care Manager with whom you conduct reviews.

Provider Coverage During Absences

A provider must contact ValueOptions® of California to discuss alternative provider coverage arrangements in any situation (i.e., military assignment, maternity leave, sabbatical, extended vacations, or illness) when he or she is unable to treat ValueOptions® of California members in active treatment. Two types of notification to ValueOptions® of California are required regardless of the reasons:

1. You must contact the Clinical Care Manager with whom you conduct reviews informing them of your current caseload or need to transition members; and
2. You must also provide a written notice to the ValueOptions®, Inc. National Network Operations Department at the address listed below. Written notice should include name, licensure, practice locations affected, reason for absence and date range of absence.

Mail: ValueOptions®, Inc.
C/o Practitioner Maintenance
P.O. Box 41055
Norfolk, VA 23541

OR

Fax: (866) 612-7795

Termination and Absences

ValueOptions[®] of California will contact the provider by letter to inform him/her that the leave of absence time has expired and request a response within thirty (30) calendar days or risk network termination. If no response is received from the provider, the provider is automatically forwarded to ValueOptions[®], Inc. National Network Services for disenrollment. If a provider remains on inactive status for longer than twelve (12) consecutive months (with the exception of military assignment), a 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 ValueOptions[®] of California that their absence from the network is ended and the date of return. When a provider indicates that they are reactivating network status, ValueOptions[®], Inc. National Network Services reviews the provider file, conducts PSV, and sends a recommendation to the ValueOptions[®] of California Credentialing Committee. If the provider indicates that he or she would like to extend the leave of absence beyond twelve (12) consecutive months, 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 provider's regular business hours, ValueOptions[®] of California, 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 ValueOptions[®] of California 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.

Compliance with National Provider Identifier (NPI)

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