

## Understanding your Empire Plan Explanation of Benefits

*To assist you in receiving your payment promptly, we have compiled a list of the most common reasons a claim is denied and how to avoid it in the future:*

<b>Denial Message:</b>	<b><i>“The date for this <u>service</u> was <u>not</u> <u>preauthorized</u>. No payment will be made. See your Certificate of Insurance for more information.”</i></b> <b><i>-OR-</i></b> <b><i>“The maximum number of approved visits has been reached. <u>Additional</u> <u>sessions</u> <u>must</u> <u>be</u> <u>preauthorized</u>.”</i></b>
<b>Common Causes:</b>	The dates of service are not authorized or fall outside of the authorization period. The initial 10 visits are per provider per lifetime, and allow for an initial evaluation (90801) and 9 follow-up visits. Authorization is required if treatment continues beyond these 10 visits.
<b>Ways To Avoid:</b>	The Empire Plan allows for ten(10) initial visits: one(1) 90801 Initial Evaluation and nine(9) 90806 follow-up visits. If treatment is to continue beyond these initial 10 sessions an Outpatient Registration Form (ORF1) must be submitted prior to the 11 <sup>th</sup> visit (preferably around the 7 <sup>th</sup> visit). Authorization can be requested on line at <a href="http://www.valueoptions.com">www.valueoptions.com</a> or faxed to (866) 757-5101.

<b>Denial Message:</b>	<b><i>This claim was not filed within the required time period. No payment will be made. See your Certificate of Insurance for more information.</i></b>
<b>Common Causes:</b>	Claim was received after the filing deadline of March 31st.
<b>Ways To Avoid:</b>	Claims must be <u>received</u> within 90 days after the end of the calendar year in which the covered expenses were incurred (March 31st). If the claim is first sent to Medicare or the primary carrier, it must be received within 90 days after Medicare/carrier processes the claim.

<b>Denial Message:</b>	<b><i>We are not able to identify the provider or the discipline. Please resubmit with more information.</i></b>
<b>Common Causes:</b>	Individual Provider name and/or licensure level is missing or illegible. Signature of Physician field (box 31 on CMS-1500, box 82 on UB-04) is blank.
<b>Ways To Avoid:</b>	This information is required in order to process claims. Ensure provider name is legible and licensure is included and accurate. Please resubmit a corrected claim within the timely filing guidelines.

<b>Denial Message:</b>	<b><i>We have already paid this claim.</i></b>
<b>Common Causes:</b>	A claim for this date of service has already been submitted. Claims received are entered within 14 days. Dates of service on the claim are a duplicate of services paid (match on date of service, CPT4, and provider) or ValueOptions may still be processing the original claim.
<b>Ways To Avoid:</b>	Our recommendation is that you allow 30 days (to include mailing time) before submitting another claim. Check to see if claim is in process before submitting another by obtaining claims status on line at <a href="http://www.valueoptions.com">www.valueoptions.com</a> or by contacting Customer Service at 1-800-446-3995.

<b>Denial Message:</b>	<b><i>These services were not covered by the ValueOptions/mental health plan. Please send the claim to United Health Care.</i></b>
<b>Common Causes:</b>	<p>The claim has a diagnosis, procedure, and provider licensure level that is outside of NYS Empire Plan's covered ranges.</p> <p>For Example: Laboratory procedures should be billed to the medical carrier. We deny any claim to UHC billed on a medical claim form that has a diagnosis outside the range of 290.00 – 319.90.</p>
<b>Ways To Avoid:</b>	Resubmit the claim to United Health Care ( <a href="http://www.unitedhealthcareonline.com">www.unitedhealthcareonline.com</a> ) for proper claims handling.

<b>Denial Message:</b>	<b><i>To process this claim please return the Medicare Explanation of Benefits with this Empire/VO EOB. Send it to: ValueOptions, PO Box 778, Troy, NY 12181</i></b>
<b>Common Causes:</b>	The member has Medicare insurance as primary coverage and the claim for this date of service did not have a valid Medicare EOB (explanation of Benefits) attached.
<b>Ways To Avoid:</b>	<p><u>Step 1:</u> Verify the insurance coverage with the member or verify eligibility by contacting Medicare.</p> <p><u>Step 2:</u> Providers are responsible to submit claims to Medicare even if they do not participate with Medicare program.</p> <ul style="list-style-type: none"> <li>• Providers who participate with Medicare should submit claims to ValueOptions when the Explanation of Medicare Benefit (EOMB) with denial or partial payment is received.</li> <li>• Providers who once participated with Medicare can obtain an OPT OUT letter and should submit a current letter with each claim submission to ValueOptions.</li> <li>• Providers who have never participated with Medicare must submit claims to Medicare and obtain an EOMB with denial. Once the EOMB is obtained claims can be submitted to ValueOptions.</li> </ul> <p>Authorizations for visits must be obtained by submitting an Outpatient Registration form to ValueOptions. Authorization can be requested on line at <a href="http://www.valueoptions.com">www.valueoptions.com</a> or faxed to (866) 757-5101.</p>