

General Motors Frequently Asked Questions/General Information

Q: What is the effective date that this transition will occur?

A: ValueOptions® is expanding its administration of mental health and substance abuse benefits for General Motors employees/retirees and their dependents that are enrolled in a Blue Cross Blue Shield medical plan. Starting **January 1, 2010**, General Motors has contracted with ValueOptions®, Inc. (ValueOptions®) and its associated treatment providers to develop and maintain a comprehensive provider network. ValueOptions® will also process claims for behavioral health services and provide customer service support for all dates of service 1/1/2010 and forward.

Q: What telephone number do I call to contact ValueOptions®?

A: For your clinical and customer service needs, the contact numbers will not change. Please use the same phone number on the General Motors member's identification card and follow the prompts and you will be connected to ValueOptions®. For future reference that number is 800.235.2302.

For provider contracting and credentialing questions, please contact ValueOptions® Provider Relations department at **1-800-397-1630**.

Q: How can I join the network for General Motors?

A: If you are a ValueOptions® participating provider, your current contract with ValueOptions® applies to the General Motors account. If you are not a current ValueOptions® provider, you may request an application by calling the National Provider Line at **1-800-397-1630**.

Q: What if I do not want to participate with ValueOptions®?

A: You must notify ValueOptions® in writing that you wish to terminate your agreement, in accordance with the termination provision in your Participating Provider Contract.

Transition of Care

The following provisions for transitioning care will cover these populations:

- Salaried – Active/Retirees
- Other Hourly – Active/Retirees
- IUE – Active/Retirees

To be covered under the provisions, care must begin on or before 11:59PM, 12/31/2009.

Care started on or after 12:00 midnight, 01/01/2010, will be administered by **ValueOptions®**.

A. Transition Provisions for Inpatient (IP), Partial Hospital Program (PHP), or Residential Treatment Care (RTC):

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1. Any patient receiving inpatient (including acute care, detoxification, intensive care and residential rehabilitation), partial hospital, or residential care on or before 12/31/09, will be managed by the current vendor, CIGNA Health, for the entire length of stay (into 2010) as long as the admission remains at that level of care and is medically necessary. The claim for the entire length of stay will be adjudicated and paid by CIGNA Health. **ValueOptions®** will manage the case when the patient is discharged or transitioned to a different level of care.
2. Any patient admitted to inpatient (including acute care, detoxification, intensive care and residential rehabilitation), partial hospital, or residential care on or after 01/01/2010 will be managed by **ValueOptions®**.

Q: What is the transition of care plan for members whose providers are not participating in the ValueOptions® network on January 1, 2010?

- A.** For providers who choose not to contract with ValueOptions® on January 1, 2010, the following transition of care timeframe will apply for medically necessary treatment: The transition of care benefit is in effect for up to 90 days and ends on March 31, 2010.

If a provider decides not to join the ValueOptions® network and no out-of-network benefit is available, a member will need to transition to a network provider

Transition of care is designed to give the member the opportunity to complete treatment or to arrange transfer to an in network provider when required by the General Motors benefit plan. After January 1, 2010, please call ValueOptions® at the number on the member's Blue Cross Blue Shield identification card and follow the prompts to verify the provisions and limitations of the member's benefit.

Authorization for Care Prior to and After January 1, 2010:

Higher Levels of Care (Inpatient, Partial Hospitalization and Residential)

- If you are treating a General Motors UAW member at an **Inpatient level of care** that requires telephonic authorization and the member was admitted prior to January 1, 2010, you will continue to review with ValueOptions®. ValueOptions® will continue to manage that prior authorization and concurrent review. Claims for the inpatient service would be submitted to CIGNA for payment. Claims incurred after the step down should be submitted to ValueOptions® at PO Box 930829, Wixom, MI 48393-0829
- If you are treating a General Motors member currently managed by CIGNA as the behavioral health provider at an **Inpatient level of care** that requires telephonic authorization and the member was admitted prior to January 1, 2010, you will continue to review with CIGNA. Claims for the inpatient service would be submitted to CIGNA for payment.
- For any member that needs a step-down level of care; you must contact ValueOptions® to preauthorize this care on or after January 1, 2010. Claims incurred after the step down should be submitted to ValueOptions® at PO Box 930829, Wixom, MI 48393-0829

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- For inpatient care needed on or after January 1, 2010, providers will need to contact ValueOptions® for preauthorization of non-emergent admissions and preauthorization of post-stabilization care for emergency admissions. Please use the number on the back of the member's Blue Cross Blue Shield identification card (800.235.2302), or visit ProviderConnect at www.valueoptions.com/pclogin to authorize care. Telephonic review is available 24 hours a day, seven days a week.

Alternative Level of Care (Intensive Outpatient, etc.)

- For members in alternative levels of care initiated and authorized by ValueOptions® prior to January 1, 2010, whose care needs to continue after January 1, 2010, you must contact ValueOptions® via ProviderConnect at www.valueoptions.com/pclogin or by using the number on the back of the member's Blue Cross Blue Shield identification card by the last authorized date of the previous authorization.
- For alternative level of care needed on or after January 1, 2010, providers will need to contact ValueOptions® via ProviderConnect at www.valueoptions.com/pclogin or by calling the number on the back of member's Blue Cross Blue Shield identification card (800.235.2302)
- NOTE: Claims should be split depending on the dates of service:
 - Claims for dates of service before January 1, 2010, need to be sent to CIGNA
 - If the member continues in the same alternative level of care on and after January 1, 2010, the claims should be sent to the ValueOptions® claims address noted below.

Continued Stay review:

- Inpatient and higher levels of care (PHP, IOP) require telephonic review with a ValueOptions® Clinical Care Manager. All requests for authorization of continued stays should be made in advance of the expiration of the preauthorization so that no lapse in services occurs. Please call the appropriate number on the member's Blue Cross Blue Shield identification card or contact ValueOptions® via ProviderConnect at www.valueoptions.com/pclogin.
- **Please note that it is the provider's responsibility to call ValueOptions® to request continued stays or concurrent reviews.** This information is found in our **Provider Manual which can be accessed at www.valueoptions.com.**
- Failure to initiate concurrent review, via a telephone call or online submission, may result in non-payment of claims.

Outpatient Levels of Care

- To meet Federal Mental Health Parity, in network outpatient benefits will no longer require preauthorization for GMC salaried, IUE, and Other Hourly members. However, UAW bargained plans do require pre-authorization. The pre-authorization requirement as well as any registration requirements has been discontinued for GMC salaried, IUE, and Other hourly members. ValueOptions® will utilize three (3) levels of outpatient outlier management:
 - Outlier management by diagnostic category
 - Complex and high cost cases
 - Provider outlier management

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- **Outlier Management by diagnostic category:** For case with diagnoses that have extreme variability in treatment duration, intensity and outcome, ValueOptions® will request detailed information for review.
- **Complex and high cost cases:** For individual members with complex illness, ValueOptions® will contact the treatment provider early in the treatment regimen in order to develop, in conjunction with the provider, an individualized care plan.
- **Provider outlier management:** If an individual provider's treatment patterns within a diagnosis vary significantly from norms, additional information will be requested for review.
- Providers can access ValueOptions® Customer Service via ProviderConnect at www.valueoptions.com/pclogin or submit treatment requests by faxing an ORF2 to 248.697.0908.
- The member's benefit plan will define whether or not the member has coverage for out-of-network (OON) providers.
- Those GMC salaried, IUE and Other Hourly members that have out-of-network coverage, the above will apply for them as well. Providers can access ValueOptions® Customer Service by submitting treatment requests by faxing an ORF2 to 248.697.0908.
- **As UAW-GM active hourly members are not required to meet mental health parity at this time, ValueOptions® will continue to require that all outpatient services be pre-authorized.**
 - Forms are available at www.valueoptions.com.
 - Failure to submit the treatment request may result in *non-payment* of claims.
- Providers should **submit claims** in accordance with the ValueOptions® claims procedures. Details regarding ValueOptions® claims procedures can be accessed through the ValueOptions® website (www.valueoptions.com).

Provider Network – Contracting and Credentialing

Q: I currently participate with ValueOptions®. What do I have to do?

A: You do not have to do anything further; your current ValueOptions® Agreement applies to the General Motors members. If you have any questions regarding your network status, please contact ValueOptions® at 1-800-397-1630.

Q: I am not a provider in the ValueOptions® network. What do I do to join the network?

A: If you are not a current ValueOptions® provider, you may request an application by calling the National Provider Line at **1-800-397-1630**

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What Do I Do Next?

ValueOptions® will continue to update this Frequently Asked Questions' (FAQ) document when more information is available. These updates will be available at www.valueoptions.com. If you have questions please call the ValueOptions® Provider Line at 1-800-397-1630.

Q: What fee schedule will be used if I intend on becoming a ValueOptions® provider?

A: Effective January 1, 2010, the ValueOptions® Fee Schedule you receive in your packet details the payment (by CPT Code and licensure) that you will receive for providing covered services to the General Motors membership.

Q: My current Outpatient fee schedule is more favorable than ValueOptions®, fee schedule. With whom do I discuss my ValueOptions® fee schedule?

A: The ValueOptions® fee schedules for outpatient services are reviewed routinely and at present are determined to be competitive with other companies with similar business across the United States. In general, our fee schedules for outpatient services are non-negotiable.

If you believe that your fee schedule needs to be reviewed, please submit a Letter of Request regarding Rate Schedule to:

**Provider Relations
ValueOptions®
48561 Alpha Dr.
Suite 150
Wixom, MI 48393**

You must include the following in the letter:

- Last Name, First Name
- Tax Identification or Social Security number
- Primary Mailing Address, City, State, Zip
- Practice address(s) with City, State, Zip
- Primary contact number with area code
- Name of Primary contact if different than your own
- List of codes and counter proposed rates

Q: Do I have to be credentialed by ValueOptions®?

A: Yes, all providers need to be credentialed by ValueOptions® to be included within the General Motors/ValueOptions® provider networks.

Q: I just completed my credentialing/recredentialing with ValueOptions® for the GM Careline and I do not participate with ValueOptions®; do I need to credential again?

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- A:** No. ValueOptions® will send you a ValueOptions® Provider Agreement. Your credentialing for the GM Careline will apply for the ValueOptions® network. You will be notified by ValueOptions® when you are due for recredentialing based on the date you were last credentialed. Recredentialing is required every three (3) years.

Online Services

- Q:** What online services does ValueOptions® offer?

- A:** ValueOptions® has enhanced our on-line services to provide added convenience for our members and providers. The following services are available:

ProviderConnect is an enhanced version of our online transaction services. It is a self-service tool available 24/7 that gives you access to the following features: authorization requests for all levels of care, concurrent review requests and discharge reporting, single and multiple electronic claims submission, claims status review (for both paper and online submitted claims), eligibility status, enter an outpatient authorization request, submit an inquiry to customer service, your provider practice profile, and correspondence (which includes authorizations letters and the ability to print provider summary vouchers) Find more information about ProviderConnect on www.valueoptions.com

Claims

CIGNA Health will be responsible for reimbursement of pre-certified inpatient admissions commencing prior to January 1, 2010 and any other services rendered **PRIOR** to January 1, 2010; therefore, please submit claims with dates of service prior to January 1, 2010 to:

**CIGNA Health
PO Box 5132
Southfield, MI 48086**

ValueOptions® will be responsible for reimbursement of pre-certified services rendered **ON or AFTER** January 1, 2010. Please submit these claims electronically or by paper to:

**PO Box 930829
Wixom, MI 48393-0829**

Any questions regarding claims for dates of service on or after January 1, 2010, should be directed to ValueOptions® by calling 800.235.2302

- Q:** What paper forms can be used for claims submission for dates of service on or after January 1, 2010?

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- A:** Providers are required to bill on standard CMS 1500 and UB04 forms. Red ink forms should be used as these can be scanned, which expedites the claim entry into the claims system. The UB04 Form can only be used for inpatient and alternative levels of care for mental health and substance abuse, not outpatient professional mental health services. The CMS 1500 form should be used for outpatient professional services.
- Q: Can I submit my claims electronically to ValueOptions® for dates of service on or after January 1, 2010?**
- A:** Yes. CMS 1500 and UB04 (837P and 837I) electronic submissions are accepted according to guidelines contained in the ValueOptions® EDI materials found on www.valueoptions.com. If you are interested in electronic claim submission, please contact our ValueOptions® Electronic Claims Specialist at 888-247-9311. We strongly encourage providers to submit claims electronically for the efficiencies gained by both providers and in claims processing.
- Q: Does the ValueOptions® electronic claims format work with other claims clearing houses?**
- A:** Please contact our ValueOptions® Electronic Claims Specialist at 888-247-9311. Please note: ValueOptions® does not reimburse for provider expenses associated with electronic claims submission.
- Q: When ValueOptions® authorizes care is the authorization an automatic guarantee of payment for services rendered?**
- A:** No, authorization of services is **not** a guarantee of payment. Payment depends on a number of factors including member eligibility, provider contract status, and benefit limits at the time care is rendered.
- Q: As an individual practitioner billing outpatient services, do I need to include the provider number on my claims?**
- A:** Outpatient professional services must be billed on a CMS-1500 form. The following fields are required.

CMS-1500 required fields:

• Insured's ID number	• Dates of service
• Patient's name	• Place of service
• Patient's birth date and gender	• Procedures, services or supplies CPT/HCPCS
• Insured's name	• Procedures, services or supplies modifier
• Patient's address, city, state, zip code and telephone number	• Charges

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<ul style="list-style-type: none"> • Patient's relationship to the insured 	<ul style="list-style-type: none"> • Days or units
<ul style="list-style-type: none"> • Insured's address, city, state, zip code and telephone number 	<ul style="list-style-type: none"> • Federal Tax ID number and type
<ul style="list-style-type: none"> • Patient status – married / single 	<ul style="list-style-type: none"> • Signature of physician or supplier including degrees or credentials
<ul style="list-style-type: none"> • Is the patient's condition related to: Employment? Auto accident? Other accident? 	<ul style="list-style-type: none"> • Name and address of facility where services were rendered
<ul style="list-style-type: none"> • Is there another health benefit plan? 	<ul style="list-style-type: none"> • Physician's/supplier's billing: name, address, zip code and phone number
<ul style="list-style-type: none"> • Diagnosis or nature of illness or injury 	<ul style="list-style-type: none"> • NPI

Q: For claims with dates of service on or after January 1, 2010, which were previously rejected and need to be resubmitted, what do I need to do?

A: Provider should clearly write "Corrected Claim" on these types of claims and send to:

**PO Box 930829
Wixom, MI 48393-0829**

Providers need to be aware of the timely filing requirements as stated in their contract with ValueOptions®. This pertains to first time submissions, as well as re-submissions on a previously processed claim.

Q: As a facility billing for outpatient services, what information is required on my claims?

A: Outpatient professional services must be billed on a CMS-1500 form. Please see the required fields listed above. In addition, please visit www.valueoptions.com for more information on proper billing procedures.

Q: As a Facility billing for services other than outpatient, how do I bill?

A: Inpatient services and Alternate Levels of Care (PHP, IOP, etc.) must be billed on a UB-04 form. The following fields are required:

UB-04 Required Fields:

<ul style="list-style-type: none"> • Servicing provider name, service address & phone # 	<ul style="list-style-type: none"> • Service units
<ul style="list-style-type: none"> • Type of bill 	<ul style="list-style-type: none"> • Total charges
<ul style="list-style-type: none"> • Federal tax number 	<ul style="list-style-type: none"> • Payer

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• Statement covers “From” and “Through”	• Release of information certification indicator
• Patient’s name (last, first, middle initial)	• Assignment of Benefits
• Patient’s address	• Insured’s name (last, first name, middle initial)
• Birth date	• Patient’s relationship to insured
• Sex	• Certificate No. – Social Security Number – Health Insurance Claim Identification Number
• Marital status	• Group name
• Admission date	• Principal diagnosis code
• Patient status	• Admitting diagnosis code
• Admission date	• Attending physician identification number
• Patient status	• Provider representative
• Responsible party name and address	• Date
• Revenue code	• NPI
• Service date	• Provider Billing Address

In addition, please visit www.valueoptions.com for more information on proper billing procedures.

Q: Who pays when the member is admitted to a medical unit for alcohol withdrawal treatment?

A: Claims for Detox on Medical units should be submitted to ValueOptions®.

Q: Who is responsible for members admitted to an inpatient medical unit with behavioral health issues that need to be treated?

A: Members admitted to a medical floor are the responsibility of the medical plan. Authorization is required by the medical plan and claims are paid by the medical plan. If the member is transferred to a psychiatric or substance abuse unit ValueOptions® will need to review, authorize the care, and pay the claims.

Q: Who is responsible for members admitted to a behavioral health unit?

A: Members admitted to a behavioral health unit require an authorization by ValueOptions®. Please contact ValueOptions® and request an authorization.

Q: For dates of service on or after January 1, 2010, where do I go to have a claim question/issue resolved?

A: Please visit us on-line at www.valueoptions.com to check and review a claim status or call 800.235.2302.

Clinical, Authorization and Quality Services

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Q: What are the hours of the ValueOptions® Clinical Department?

A: Licensed clinicians are available 24-hours a day, 7 days a week, and 365 days a year. It is imperative that, in the event of emergent care, the provider contact ValueOptions® as soon as possible, but no later than 24-hours after the emergent contact/session/admission. Information can also be submitted online using ProviderConnect at www.valueoptions.com.

Q: As an inpatient Provider, how soon after an admission do I have to authorize care?

A: Pre-authorization is required for all non-emergent services; however, after completing the evaluation, the provider should contact ValueOptions®. Please call ValueOptions® by dialing the number on the back of the member's insurance card (800.235.2302) to review the emergency, what services are offered, and the clinical information. This includes nights, weekends, and holidays, as our phone lines are open 24 hours a day 7 days a week, 365 days a year.

Q: As a provider, how soon will I receive a claims payment?

A: Clean claims submitted electronically within timely filing limits set out in your contract will be processed and paid or additional information requested where required within 30 days of receipt. Reimbursement for covered services shall be at the rates specified in your contract.