

VALUEOPTIONS® RESOURCE GUIDE FOR HORIZON BEHAVIORAL HEALTHSM

Table of Contents

<u>Overview</u>	<u>4</u>
<u>About ValueOptions.....</u>	<u>4-9</u>
Contact Information	5
Electronic Requirements	6
Electronic Resources.....	6
ProviderConnect®	6
CAQH	6
ValueOptions.com.....	7
Achieve Solutions®	7
Participating Providers.....	7
ValueOptions Provider Identification Numbers.....	7
Provider Satisfaction Survey.....	8
Changes to ValueOptions Provider Records.....	8
Policies & Procedures	9
<u>Credentialing & Re-Credentialing.....</u>	<u>9-13</u>
Credentialing.....	9
Re-Credentialing	10
Standards.....	11
Site Visits.....	12
Updates.....	12
Delegation.....	13
<u>Sanctions.....</u>	<u>13-15</u>
<u>Appeals of National Credentialing Committee (NCC)/Provider Appeals Committee (PAC) Decisions</u>	<u>15</u>
<u>Office Procedures.....</u>	<u>16-18</u>
Member Rights & Responsibilities.....	16
Access to Treatment Records & Treatment Record Reviews/Audits.....	16
Confidentiality, Privacy & Security of Identifiable Health Information.....	17
Appointment & Availability Standards.....	17
Out-of-Office Coverage	18
Termination and Leave of Absence	18
Requests for Additional Information	18
<u>Services to Members</u>	<u>19-20</u>
Emergency Services.....	19

Referrals	19
On Track Outcomes	20
Coordination with Primary Care/Treating Providers	20
Continuation Following Provider Agreement Expiration or Termination	20
Fraud, Waste and Abuse.....	21

Horizon Behavioral Health Program Complaints, Grievances & Appeals22

Claims Procedures.....22

Utilization Management23-35

Healthcare Effectiveness Data Information Set (HEDIS).....	23
New & Emerging Technologies	26
Treatment Planning.....	26
Clinical Review Process	27
Definition of Medical Necessity.....	29
Clinical Criteria.....	30
Treatment Guidelines.....	31
ValueOptions’ Care Management System.....	31
Clinical Care Manager Reviews.....	31
Inpatient or Higher Levels of Care	33
Discharge Planning.....	34
Case Management for patients that meet high-risk criteria	34
Adverse Clinical Determination/Peer Review	35
Electroconvulsive Therapy.....	35
Outpatient Services.....	35

Appeal of Adverse Determinations36-39

Clinical Appeals.....	37
Administrative Appeals.....	38
Final Appeal Level.....	39

Quality Management/Quality Improvement.....37-39

QM Committees	39
Scope of the Quality Management Program	40
Role of Participating Providers.....	40
Quality Performance Indicator Development and Monitoring Activities	41
Service Availability and Access to Care.....	42
Continuity and Coordination of Care.....	43
Treatment Record Standards & Guidelines	43
Treatment Record Reviews	44
Improving Patient Safety	44
Professional Review/Fair Hearing Process	45
Adverse Incidents	46
Quality Improvement Activities/Projects.....	46
Experience/Satisfaction Surveys	46

Site Visits for Quality Reviews..... 47
Complaints and Grievances 47

Appendices

- I. [Clinical Criteria](#)**
- II. [Treatment Guidelines](#)**
- III. [Clinical Recommendations and Best Practices \(links to newly created Horizon-specific document\)](#)**
- IV. [Member Rights \(English\) \(PDF\)](#)**
- V. [Member Rights \(Spanish\) \(PDF\)](#)**
- VI. [Administrative Forms](#)**
- VII. [Clinical Forms](#)**
- VIII. [Medicare Advantage Specific Provisions](#)**

[Back to Table of Contents](#)

Overview

This *ValueOptions Resource Guide* was created by ValueOptions®¹, the administrator of the Horizon Behavioral Health^{SM2} program, to assist participating providers/hospitals in understanding policies and procedures regarding behavioral health.

Questions, comments and suggestions regarding this *ValueOptions Resource Guide* should be directed to ValueOptions at (800) 397-1630.

[Back to Table of Contents](#)

About ValueOptions

ValueOptions is a health improvement company that serves more than 32 million individuals and is a national leader in the fields of mental and emotional wellbeing, recovery and resilience, employee assistance, and wellness. Selected by Horizon BCBSNJ to manage its behavioral health services effective July 1, 2014, ValueOptions works on behalf of Horizon BCBSNJ and manages recruiting, contacting, credentialing and recredentialing for Horizon PPO and Horizon Managed Care Networks, and the Medicare Advantage plans.

ValueOptions does not specifically offer rewards or incentives, financial or otherwise, to its *utilization management* staff, contractors, *participating providers*, *Clinical Care Managers (CCMs)*, *Peer Advisors* or any other individuals or entities involved in making *medical necessity* determinations for issuing denials of coverage or service or that are intended to encourage determinations that result in underutilization. *Utilization management* decisions are based only on appropriateness of care and service and existence of coverage.

[Back to Table of Contents](#)

¹ 'ValueOptions' is a registered service mark of ValueOptions, Inc. Any use of or reference to 'ValueOptions' in any communication, publication, notice, disclosure, mailing or other document, whether written or electronic, requires the prior written *authorization* of ValueOptions, Inc.

² Horizon Blue Cross Blue Shield of New Jersey is an independent licensee of the Blue Cross and Blue Shield Association. The Blue Cross® and Blue Shield® names and symbols are registered marks of the Blue Cross and Blue Shield Association. The Horizon® name and symbols are registered marks of Horizon Blue Cross Blue Shield of New Jersey. © 2014 Horizon Blue Cross Blue Shield of New Jersey. Three Penn Plaza East, Newark, New Jersey 07105.

Contact Information

<i>Administrative Appeal</i>	To request an <i>administrative appeal</i> , call the toll free number included in the administrative denial letter received.
<i>Adverse Incident</i>	Report all <i>adverse incidents</i> to the <i>Clinical Care Manager</i> with whom the <i>participating provider</i> conducts reviews.
Changing your <i>Provider Profile</i> (e.g. Name, address)	<p>To change or update your Provider Profile (e.g. address), the preferred method to do so is via ProviderConnect and selecting the “Update Demographic Information” option.</p> <p>Providers without access to ProviderConnect can submit a “Change of Address” form, available at ValueOptions.com by fax or to:</p> <p>ValueOptions c/o Practitioner Maintenance P.O. Box 41055 Norfolk, VA 23541 Fax: (877) 722-0987</p> <p><u>NOTE:</u> A change of address requires an accompanying W-9 form, can also be submitted as an attachment within ProviderConnect. A copy of the W-9 form is available at ValueOptions.com.</p>
Claims	All behavioral health claims should be submitted to Horizon according to Horizon’s electronic claims processing procedures. Please refer to the <i>Horizon Provider Training Manual</i> for procedures related to claim submission and inquiries.
<i>Clinical Appeals</i>	To request a <i>clinical appeal</i> , call the toll-free number included in the adverse determination letter received.
<i>Complaints/Grievances</i>	To file a general <i>complaint/grievance</i> , call Horizon Behavioral Health at 1 (800) 626-2212 or the toll-free number on the back of the <i>member’s</i> identification card to speak to Customer Service.
Credentialing Status	To obtain information pertaining to network participation status, contact ValueOptions’ National Provider Line at (800) 397-1630 from 8am-8pm Eastern Time.
<i>Fraud and Abuse</i>	<p>Reports of questionable billing practices or suspected <i>fraud</i> may be made in writing to:</p> <p>Mailing Address: ValueOptions, Inc. National Headquarters ATTN: Special Investigations Unit 240 Corporate Boulevard Norfolk, VA 23502</p> <p>OR</p>

	Contact ValueOptions Provider Services Line at (800) 397-1630 Monday through Friday, 8 a.m. to 8 p.m. EST.
<i>Member Benefits</i>	Member benefit information can be accessed through NaviNet®. Please refer to the <i>Horizon Provider Training Manual</i> for procedures related to this topic.
<i>Member Eligibility, and Authorizations</i>	For questions about authorizations, the preferred method to do so is via ProviderConnect by selecting the “Eligibility and Benefits” and/or “Review an Authorization” option. Providers can also access Member Eligibility information through NaviNet.
<i>Member Customer Service</i>	To reach <i>Member Customer Service</i> , call the toll-free number on the back of the <i>member’s</i> identification card.
<i>Provider Coverage During Absences</i>	To update ValueOptions if there will be lack of provider coverage due to absences (e.g. coverage while on vacation), contact the <i>Clinical Care Manager</i> with whom the <i>participating provider</i> conducts reviews during absences, or call the number on the <i>member’s</i> card to provide coverage information.
<i>Provider Supporting Documentation</i>	To send supporting documentation such as malpractice or insurance cover sheets please fax to (866) 612-7795

[Back to Table of Contents](#)

Electronic Requirements

Effective January 1, 2015, Horizon Behavioral Health/ValueOptions will require all providers/hospitals to electronically conduct all routine transactions, including:

- Verification of eligibility inquiries
- Submission of authorization requests
- Updating of provider information

To conduct these transactions referenced above, please refer to the sections in this *Resource Guide* titled “Electronic Resources” and “Updating Provider Information.”

Additionally, Horizon reserves the right to require providers to submit claims to Horizon according to Horizon’s electronic claims processing procedures. Please refer to the *Horizon Provider Training Manual* for procedures related to this topic.

Electronic Resources

The following electronic solutions are available to assist providers/hospitals in complying with Horizon Behavioral Health/ValueOptions’ electronic requirements. Please note: Use of these electronic solutions will be required beginning January 1, 2015.

ProviderConnect®

ProviderConnect is a secure, password protected site where *participating providers/hospitals* conduct certain online activities with ValueOptions directly twenty four (24) hours a day, seven (7) days a week (excluding scheduled maintenance and

unforeseen systems issues). Currently, *Horizon providers/hospitals* are provided access to the following online activities: *authorization* or *certification* requests for all levels of care, *concurrent review* requests and discharge reporting, verification of eligibility status, submission of inquiries to Horizon Behavior Health's Provider Customer Service, updates to practice profiles/records, and electronic access to *authorization/certification* letters.

Council for Affordable Quality Healthcare (CAQH)

Horizon BCBSNJ providers can utilize CAQH's Universal Provider Datasource (UPD) for initial or recredentialing processes. The CAQH UPD gives providers a rapid and simple solution to securely submit credentialing information to multiple health plans and networks by entering information one time only. A CAQH ID is required for those providers interested in participating with CAQH. Providers must also give authorization to Horizon BCBSNJ and ValueOptions to release their application in order for the application to become available to them.

ValueOptions.com

ValueOptions' website (www.ValueOptions.com) contains information about ValueOptions and its business. Links to information and documents important to *providers* are located here at the Provider section, including additional information pertaining to ValueOptions' Electronic Requirements. Information specific to Horizon Behavioral Health is also available at www.ValueOptions.com/horizon.

ValueOptions' Notice of Privacy of Practices regarding use of the website is located at *ValueOptions.com*.

Please note, the ValueOptions.com Terms and Conditions, including but not limited to limitations on liability and warranties, apply to the installation and use of, and any technical assistance related to the installation or use of this software. Technical assistance includes but is not limited to any guidance, recommendations, instructions or actions taken by ValueOptions or its employees, including where such activity is performed directly on your system, device or equipment by a ValueOptions, Inc. employee or other representative.

Achieve Solutions®

Achieve Solutions® is an educational behavioral health and wellness information ValueOptions.com website. This ValueOptions.com website is educational in nature and is not intended as a resource for emergency crisis situations or as a replacement for medical care or counseling. Providers can access the Achieve Solutions website for Horizon Behavioral Health at

<https://www.achievesolutions.net/achievesolutions/en/horizonbehavioralhealth/Home.do>.

[Back to Table of Contents](#)

Participating Providers

ValueOptions does not refuse to contract with or terminate existing contractual relationships with *providers* because a provider: (a) advocates on behalf of a *member*, (b) files a *complaint* with or against ValueOptions, or (c) *appeals* a decision or determination made by ValueOptions.

Participating providers are independent contractors of ValueOptions. This means that *participating providers* practice and operate independently, are not employees of ValueOptions, and are not partners with or involved in a joint venture or similar arrangement with ValueOptions. ValueOptions does not direct, control or endorse health care or treatment rendered or to be rendered by *providers* or *participating providers*.

ValueOptions encourages *participating providers/hospitals* to communicate with *members* to discuss available treatment options, including medications and available options, regardless of coverage determinations made to or to be made by ValueOptions or a designee of ValueOptions. Treating *providers*, in conjunction with the *member* (or the *member's* legal representative), make decisions regarding what services and treatment are rendered. Any *preauthorization, certification* or *medical necessity* determinations by ValueOptions relate solely to payment. *Participating providers/providers* should direct *members* to ValueOptions or their respective benefit plan representatives for questions regarding coverage or limitations of coverage under their benefit plan prior to rendering *non-emergency* services.

ValueOptions Provider Identification Numbers

As part of the administration of Horizon's Behavioral Health program, ValueOptions assigns providers and hospitals with a unique six digit number (e.g. 123456). The *provider number* identifies the provider/hospital in the ValueOptions system and is used for giving access to ProviderConnect. Providers/hospitals should contact ValueOptions National Provider Relations at (800) 397-1630 during normal business hours Monday through Friday, 8 a.m. to 8 p.m. ET for questions regarding Provider Identification Numbers and/or for assistance in obtaining a Provider Identification Number.

The *provider's* service location vendor number is a number that identifies where services are or were rendered. A *participating provider* may have multiple vendor locations and each vendor location is given a five-digit number preceded by a letter. (e.g. A23456, D45678).

The *National Provider Identifier (NPI)* is different from what ValueOptions calls the provider number. The *NPI* is a unique 10-digit identification number issued to health care providers in the United States by the *CMS*. The *NPI* is a single provider identifier that replaces the different identifiers used in standard electronic transactions. *HHS* adopted the *NPI* as a provision of *HIPAA*. This number is also contained in the ValueOptions system and can be used to locate a provider record for referrals and *authorization* purposes.

Provider Satisfaction Survey

ValueOptions conducts an annual provider satisfaction survey to measure *participating providers'* opinions regarding ValueOptions clinical and administrative processes. Data is aggregated, trended and used to identify improvement opportunities. Results are shared with *participating providers* through the Company Quality Council CQC, Quality Management Committee, *Clinical Advisory Committees*, and provider newsletters. Corrective action plans, where appropriate, are managed through the Corporate Provider Relations Department and reported to the CQC.

Changes to ValueOptions Provider Records

Information about *participating providers'* physical addresses and locations, billing addresses, hours of operation, clinical specialties, and licensure or certification status is used in credentialing and re-credentialing activities as well in provider directories and listings made available to clients and *members*. *Participating providers* must notify ValueOptions in writing and in advance of changes or updates to information provided to ValueOptions.

Changes and updates to *participating provider* information and records should be submitted to ValueOptions via [ProviderConnect](#). If providers are unable to access Provider, changes and updates can also be submitted via mail or facsimile to the address or facsimile number noted below and using the ValueOptions Change of Address form or W-9 Substitute form accessible through the *ValueOptions.com website*.

At the time of re-credentialing, *participating providers* should make changes to information previously submitted to ValueOptions and contained in their ValueOptions Provider Record through *ProviderConnect*.

Failure to report changes in a timely manner can adversely affect participation in the network.

ValueOptions, Inc.
c/o Practitioner Maintenance
P.O. Box 41055
Norfolk, VA 23541
OR
Fax: (877) 722-0987

Policies & Procedures

Pursuant to the terms of the *provider agreement*, *participating providers* must comply with ValueOptions' *policies and procedures* and as outlined in this *ValueOptions Resource Guide*.

The CMS requires *Medicare Advantage* plans to include certain terms and provisions in *provider agreements* and in *policies and procedures*. The Appendix includes references to specific regulatory requirements and guidelines about participation in networks available to *Medicare Advantage* plans.

As more specifically detailed in other parts of this *ValueOptions Resource Guide*, ValueOptions maintains *continuous quality improvement* and *utilization management* programs that include *policies and procedures* and measures designed to provide for ongoing monitoring and evaluation of services rendered to *members* (e.g., clinical review criteria, controlled studies, *member* and *participating provider* surveys, evaluations and audits). *Participating provider* involvement is an integral part of these programs. *Participating providers* must cooperate with and participate in ValueOptions' quality improvement and *utilization management* programs and activities. Refusal to cooperate with ValueOptions' quality improvement and/or *utilization management* activities may adversely affect continued network participation status or result in sanctions up to and including termination of network participation status.

Detailed information about a specific *member's* benefit plan requirements can be obtained by viewing a *member's* benefits in NaviNet.

[Back to Table of Contents](#)

Credentialing & Re-Credentialing

ValueOptions' credentialing processes for new *providers* seeking to contract with ValueOptions and re-credentialing processes for *participating providers* currently contracted with ValueOptions is designed to comply with national *accreditation* standards to which ValueOptions is or may be subject, as well as applicable state and/or federal laws, rules and regulations. Credentialing and re-credentialing is required for all *providers* and *participating providers*, respectively, including without limitation individual practitioners and organizations (clinics, facilities or programs). All *provider/participating provider* office or facility locations where services are rendered and that share the same federal tax identification number that are identified in credentialing/re-credentialing applications will be considered for participation status under that application.

Providers and *participating providers* are credentialed and re-credentialed, respectively, for participation status for designated services and/or level(s) of services. Should *participating providers* have other or additional services or levels of services available, additional credentialing and/or re-credentialing may be necessary prior to designation as a '*participating provider*' for such additional services and/or levels of services. Services and/or levels of services for which a *participating provider* is not credentialed are subject to all applicable out-of-network *authorization*, certification and any benefit or coverage limitations under the *member's* benefit plan.

As provided for in ValueOptions' *policies and procedures*, decisions to approve or decline initial credentialing applications, to approve re-credentialing applications and/or to submit a given credentialing or re-credentialing application for further review are made by ValueOptions' *National Credentialing Committee (NCC)*, or where applicable by a local ValueOptions established credentialing committee.

Participating providers have the right to: (a) request review of information submitted in support of credentialing or re-credentialing applications; (b) correct erroneous information collected during the credentialing or re-credentialing processes; and (c) request information about the status of credentialing or re-credentialing applications. All requests to review information must be submitted in writing. Verbal requests for the status of a credentialing or re-credentialing application can be made by calling the National Network Provider Line at (800) 397-1630, Monday through Friday, 8 a.m. to 8 p.m. ET. Regardless of the above, ValueOptions will not release information obtained through the primary source verification process where prohibited by applicable state and/or federal laws, rules and/or regulations.

Credentialing

Initial credentialing processes begin with submission of completed and signed applications, along with all required supporting documentation using one of the following methods:

- After completing the online universal credentialing process offered by Council for Affordable Quality Healthcare (CAQH), give ValueOptions access to your credentialing information and ensure a current attestation. Call the CAQH Help Desk at (888) 599-1771 for answers to your questions related to the CAQH application or ValueOptions.com website; or
- Completion of a ValueOptions paper or on-line application by calling the ValueOptions National Network Provider Line at (800) 397-1630
- Completion of a New Jersey Universal Application

This includes without limitation attestation as to: (a) any limits on the *provider's* ability to perform essential functions of their position or operational status; (b) with respect to individual practitioner *providers*, the absence of any current illegal substance or drug use; (c) any loss of required state licensure and/or certification; (d) absence of felony convictions; (e) with respect to individual practitioner *providers*, any loss or limitation of privileges or disciplinary action; and (f) the correctness and completeness of the application.

Failure of a *provider* to submit a complete and signed credentialing application, and all required supporting documentation timely and as provided for in the credentialing application and/or requests from ValueOptions, may result in rejection of request for participation status with ValueOptions.

Re-Credentialing

Re-credentialing for *participating providers* is required every three (3) years, or such shorter period of time where required by a specific state law or regulation. The process for re-credentialing begins approximately six (6) months prior to the end of the initial credentialing cycle or the preceding re-credentialing cycle, as applicable and can be accomplished using one of the following methods:

- After completing the online universal credentialing process offered by Council for Affordable Quality Healthcare (CAQH), give ValueOptions access to your credentialing information and ensure a current attestation. Call the CAQH Help Desk at 1(888) 599-1771 for answers to your questions related to the CAQH application or ValueOptions.com website; or
- The mailing of a re-credentialing application via USPS to the *participating provider* or notification by ValueOptions to the *participating provider* via email, voicemail or facsimile that their online re-credentialing application is available via ProviderConnect.

Required documentation includes without limitation attestation as to: (a) any limits on the *participating provider's* ability to perform essential functions of their position or operational status; (b) with respect to individual practitioner *participating providers*, the absence of any current illegal substance or drug use; and (c) the correctness and completeness

of the application (including without limitation identification of any changes in or updates to information submitted during initial credentialing).

Failure of a *participating provider* to submit a complete and signed re-credentialing application, and all required supporting documentation timely and as provided for in the re-credentialing application and/or requests from ValueOptions, may result in termination of participation status with ValueOptions and such *providers* may be required to go through the initial credentialing process.

Standards

Standards applicable to *providers* in the initial credentialing process and to *participating providers* in the re-credentialing process include, but are not limited to the following:

- Current, unencumbered (not subject to probation, suspension, supervision and/or other monitoring requirements) and valid license to practice as an independent provider at the highest level certified or approved by the state or states in which services are performed for the *provider's/participating provider's* specialty (individual practitioners)
- Current, unencumbered (not subject to probation, suspension, supervision and/or other monitoring requirements) and valid license to practice and/or operate independently at the highest level certified or approved by the state or states in which services are performed for the *provider's/participating provider's* facility/program status (organizations)
- *Accreditation* currently accepted by ValueOptions for organizations* (currently TJC, CARF, COA, HFAP, AAAHC, NIAHO, CHAP and AOA)
- Clinical privileges in good standing at the institution designated as the primary admitting facility, with no limitations placed on the ability to independently practice in his/her specialty (individual practitioners)
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline or licensure (individual practitioners)
- Current specialty board certification, if indicated on the application (individual practitioners)
- A copy of a current Drug Enforcement Agency (DEA) certificate, and/or Controlled Dangerous Substance (CDS) Certificate where applicable (individual practitioners)
- No adverse professional liability claims which result in settlements or judgments paid by or on behalf of the *provider/participating provider* which disclose an instance of, or pattern of, behavior which may endanger *members*
- Good standing with state and federal authorities and programs (organizations)
- No exclusion or sanctions from government sponsored health benefit programs (e.g., Medicare/Medicaid) (individual practitioners and organizations)
- Current specialized training as required for certain levels or areas of specialty care (individual practitioners)
- Malpractice and/or professional liability coverage in amounts consistent with ValueOptions *policies and procedures* (individual practitioners and organizations)
- An appropriate work history for the *provider's/participating provider's* specialty (individual practitioners)

* Structured site visits are required for all unaccredited organizations.

Changes or updates to any of the above noted information is subject to re-verification from primary sources during the re-credentialing process, or at the time of notice of such a change or update from the *participating provider*.

- No adverse record of failure to follow ValueOptions' *policies and 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 potential or actual *member* endangerment
- No criminal charges filed relating to the *participating provider's* ability to render services to *members*

- No action or inaction taken by *participating provider* that, in the sole discretion of ValueOptions, results or may result in a threat to the health or well-being of a *member* or is not in the *member's* best interest

Site Visits

In addition and as part of credentialing or re-credentialing, ValueOptions may conduct a structured site visit of *provider's/participating provider's* offices/locations. Site visits include, but may not be limited to, an evaluation using the ValueOptions site and operations standards and an evaluation of clinical recordkeeping practices against ValueOptions standards.

The current ValueOptions site visit tool is available for review on the *ValueOptions.com website*. As the site visit tool is subject to modification without notice, *participating providers* are encouraged to check the *ValueOptions.com website* for the most current site visit tool prior to scheduled site visits. While ValueOptions, at its discretion, may require a site visit in the course of credentialing and/or re-credentialing processes based on information submitted and/or obtained in the process, site visits will be conducted for *providers/participating providers* in the following categories: (a) unaccredited organizations; (b) site visits required by a ValueOptions client as part of credentialing/re-credentialing activities delegated to ValueOptions; and (c) *providers/participating providers* with two or more documented *member complaints* in a six (6) month time frame relating to physical *accessibility*, physical appearance, adequacy of waiting/examining room space, or alleged quality of care issues.

Site visits are arranged in advance. Following the site visit, ValueOptions will provide a written report detailing the findings, which report may include required monitoring where applicable and/or requirements for the *participating provider* to submit an action plan.

Updates

Providers/participating providers are required to report material changes to information included in credentialing and/or re-credentialing applications submitted to ValueOptions. Except as noted below, all such changes must be reported in writing within the time period provided for in the provider agreement, but not to exceed ten (10) calendar days of the *provider/participating provider* becoming aware of the information. Failure to comply may result in immediate termination of network participation status. The following is a list (This is not an exhaustive list.) of examples of the types of material changes for which the above report is required:

- Any action against licenses, certifications, registrations, and/or *accreditation* status*
- Any legal or government action initiated that could materially affect the rendering of services to *members*
- Any legal action commenced by or on behalf of a *member*
- Any initiation of bankruptcy or insolvency proceedings, whether voluntary or involuntary
- Any other occurrence that could materially affect the rendering of services to *members*
- Discovery that a claim, suit or criminal or administrative proceeding is being brought against the *provider/participating provider* relating to the provider's malpractice, compliance with community standards and applicable laws, including any action by licensing or *accreditation* entities and/or exclusions from a government sponsored health benefit program (e.g., Medicare/Medicaid)

* The suspension, revocation, expiration and/or voluntary surrender of professional license/certification, DEA certificate, CDS certificate, and/or board certification must be reported within five (5) calendar days of the effective date of the action. (Contact ValueOptions to coordinate the transition of *members* to the care of other *participating providers* where licensure/certification no longer meets ValueOptions credentialing/re-credentialing standards and/or requirements pursuant to state and/or federal laws regarding the provision of services.)

Note: If a *participating provider* moves to or expands their practice and/or operations into another state, a copy of the *participating provider's* license/certification and malpractice/professional liability coverage is required in order

to complete primary source verification and credential the *participating provider* to treat ValueOptions members in another state.

Expiration, non-renewal and/or decrease in required malpractice or professional liability coverage must be reported thirty (30) days prior to such change in coverage.

Any changes in demographic information or changes in practice patterns such as change of services and/or billing address, name change, coverage arrangements, tax identification number, hours of operation, and/or changes in ownership must be provided to ValueOptions in advance of such changes. ValueOptions must receive 60 days advance notice of any new programs or services offered by a facility provider in order to allow for completion of the credentialing process prior to provision of services to *members*.

Changes in ownership and/or management of *participating providers* may require negotiation and execution of consent to assignment and assumption agreements as related to *provider agreements* and the parties to provider agreements.

Delegation

Should ValueOptions, in its sole discretion, elect to consider delegation of any credentialing and/or re-credentialing activities to a *participating provider*, such delegation is subject to all applicable *policies and procedures*, state and federal laws, rules and/or regulations, *accreditation* standards to which ValueOptions is or may be subject, and any client and/or government program specific requirements. Reference to possible delegation herein in no way obligates or requires ValueOptions to consider delegation of any credentialing and/or re-credentialing activities.

Sanctions

While efforts are made to resolve *provider/participating provider* credentialing/re-credentialing issues and/or quality issues through consultation and education, occasionally further action is necessary to provide for quality service delivery and protection of *members*. Sanctions may be imposed for issues related to *member complaints/grievances*, credentialing/re-credentialing issues, professional competency and/or conduct issues, quality of care concerns/issues, and/or violations of state and/or federal laws, rules and/or regulations. ValueOptions processes comply with all applicable local, state and/or federal reporting requirements regarding professional competence and/or conduct. Subject to modification based on the facts and circumstances in a given case, the following is a list of possible sanctions that may be imposed on *participating providers* by the ValueOptions *National Credentialing Committee (NCC)*, any ValueOptions local credentialing committee, and/or the ValueOptions Provider Appeals Committee (PAC). The descriptions below are not in any specific order and should not be interpreted to mean that there is a series of sanctions; any one or more possible sanctions described below may be imposed in any order or sequence.

Type	Definition
Consultation	<p>A call is placed to notify the <i>participating provider</i> of the alleged action or incident. The <i>participating provider</i> will be provided with an explanation of possible sanctions if corrective actions are not taken. The call will be documented to include the date and subject for consultation. A copy of the consultation will be placed in the <i>participating provider's</i> file. Appropriate educational materials will be sent via certified mail.</p>
Written Warning	<p>A written notice is sent to the <i>participating provider</i> notifying him/her of the alleged action or incident. Possible sanctions, if corrective actions are not taken, will be explained. A copy of the letter is retained in the <i>participating provider's</i> file; educational material is sent via certified mail. Corrective action will be monitored as necessary.</p>
Second Warning/ Monitoring	<p>At the discretion of the Medical Director, a second written notice may be sent to the <i>participating provider</i> and a copy of such letter shall remain in the <i>participating provider's</i> file. Additionally, the <i>participating provider</i> may be placed on monitoring when data indicates nonconformance with standards; and, if ValueOptions determines it is in the <i>members'</i> best interest, ValueOptions may elect to suspend new <i>member</i> referrals, new <i>member authorizations</i> and/or redirect all current <i>members</i> to other <i>participating providers</i>. The <i>participating provider</i> will be given written notice (and where applicable notice of <i>fair hearing</i> rights) via certified mail of the issues for which the <i>participating provider</i> is being suspended. A copy of the letter is placed in the <i>participating provider's</i> file.</p> <p><u>Facility/Program Participating Providers:</u> An action plan will be provided consisting of steps that, when taken, will remedy the deficiencies or concerns that created the need for monitoring. The <i>participating provider</i> is expected to use best efforts to comply with the monitoring action plan. If an action plan has been sent, the <i>participating provider</i> is expected to notify ValueOptions in writing of the status of the issue for which monitoring was initiated at the end of the action plan timeline, or sooner if applicable. The <i>participating provider</i> is expected to keep ValueOptions updated in writing of all changes in the issue/concern that triggered monitoring.</p>
Suspension	<p>The <i>participating provider</i> may be suspended from network participation pending resolution of issues raised. Suspension requires NCC action. During suspension, ValueOptions may elect to suspend new <i>member</i> referrals, new <i>member authorizations</i> and/or redirect all current <i>members</i> to other <i>participating providers</i>. The <i>participating provider</i> will be given written notice via facsimile and certified mail of the issues for which it is being suspended. A copy of the letter is placed in the <i>participating provider's</i> file. The suspension may last for a period of 30 calendar days during which time an investigation may take place. The NCC may extend this time</p>

	<p>period as necessary to gather additional information.</p> <p><i>Individual Participating Providers:</i> The suspension may last for a period of up to thirty (30) calendar days during which time an investigation may take place. The <i>NCC</i> may extend this time period as necessary to gather additional information.</p>
Termination	<p>The <i>participating provider</i> may be terminated from the network. Termination requires <i>NCC</i> action. The <i>participating provider</i> will be given written notice via facsimile and certified mail that the <i>participating provider</i> is being terminated from the network and the reason for the termination. A copy of the letter is put in the <i>participating provider's</i> file. <i>Members</i> in care will be notified and given assistance for referral to a new <i>participating provider</i> for continuing care, as necessary.</p>

[Back to Table of Contents](#)

Appeals of National Credentialing Committee (NCC)/Provider Appeals Committee (PAC) Decisions

The ValueOptions National Credentialing Committee (*NCC*) and ValueOptions local credentialing committees will give *providers/participating providers* written notice of the committee's decision regarding credentialing or re-credentialing applications submitted, any sanctions imposed or recommended, the reason for the decision, and of the *provider's/participating provider's* right to *appeal* adverse decisions along with an explanation of the applicable *appeals* procedure(s). Unless otherwise identified in such written notice, *providers/participating providers* have thirty (30) calendar days from the date of the committee's notice of an adverse decision to file a written request for an *appeal*.

Provider/participating provider appeals of adverse credentialing/re-credentialing decisions of a ValueOptions local credentialing committee may be appealed to the *NCC*.

The *NCC*: (a) functions as a peer review body under *NCQA* standards; (b) is made up of representatives from major clinical disciplines and includes *participating providers*; and (c) makes the final decision regarding: (i) ValueOptions credentialing/re-credentialing *policies and procedures*, (ii) approval/denial/pending status for credentialing/re-credentialing applications, and (iii) determinations regarding possible *participating provider* sanctions identified above.

Provider/participating provider appeals of adverse credentialing/re-credentialing decisions of the *NCC* may be appealed to the ValueOptions Provider Appeals Committee (PAC*).

Requests for *appeals* of adverse credentialing/re-credentialing decisions of the *NCC* should include an explanation of the reasons the *provider/participating provider* believes the *NCC* reached a decision to be in error and include supporting documentation. The PAC will review the explanation provided, the information previously reviewed by the *NCC*, and any additional information determined to be relevant. The PAC may request additional information from the *provider/participating provider* in order to make a determination or decision. The PAC will support, modify, or overturn the decision of the *NCC*. Written notification of the PAC's decision, an explanation of the decision, and any *appeal* and/or *fair hearing* rights available for adverse decisions, will be sent to the *provider/participating provider* within fourteen (14) business days after the PAC's record is complete.

* The PAC is comprised of representatives of major clinical disciplines, *participating providers* and clinical representatives from corporate departments within ValueOptions, none of whom have participated in the original NCC adverse decision under review.

Professional Review Activities/Fair Hearing Process

Individual *providers/participating providers* may request a second level of *appeal/a fair hearing* when the PAC denies credentialing, re-credentialing, issues a sanction or recommends termination of participation status of a *provider* from the ValueOptions provider network based on quality of care issues and/or issues related to professional competence or professional conduct.

Included in written notification of a PAC adverse decision based on quality of care issues and/or issues related to professional competency or professional conduct, will be an explanation of the decision, *fair hearing* rights available to the *provider/participating provider*, and an explanation of *fair hearing* procedures.

Requests for a *fair hearing* must be submitted to ValueOptions within thirty (30) calendar days of the date of the PAC notification of adverse decision to the *provider/participating provider*. While ValueOptions will make reasonable efforts to coordinate the date and time of *fair hearings* requested with the involved *provider/participating provider*, should ValueOptions and the involved *provider/participating provider* be unable to come to agreement on the date and time of the requested *fair hearing* ValueOptions will identify the date, time and location for the *fair hearing*, which date shall be within the ninety (90) calendar day period following request for the *fair hearing* or within the timeframe required by applicable State regulations.

The chair of the PAC will identify peer reviewers who will participate as the *fair hearing* panel. Every effort will be made to include a representative of the discipline of the *provider/participating provider* requesting the *fair hearing* on the panel. Members of the *fair hearing* panel will not have participated in the prior adverse decisions of the PAC or NCC, and will be asked to represent that they do not have an economic interest adverse to the *provider/participating provider*. One member of the *fair hearing* panel will be selected to act as the hearing officer and will preside over the *fair hearing*.

ValueOptions and the *provider/participating provider* each have the right to legal representation at the *fair hearing*. The *provider/participating provider* will receive the written recommendation from the panel within fifteen (15) business days after the *fair hearing*. The *fair hearing* process as set forth above is subject to applicable state and/or federal laws and/or regulations.

[Back to Table of Contents](#)

Office Procedures

Member Rights & Responsibilities

ValueOptions' *Member Rights and Responsibilities Statement* is available in English and Spanish for download from the *ValueOptions.com website*. *Participating providers* are encouraged to post the Statement in their offices or waiting rooms or distribute the Statement to *members* at their initial visit.

Access to Treatment Records & Treatment Record Reviews/Audits

ValueOptions may request access to and/or copies of *member* treatment records and/or conduct *member* treatment record reviews and/or audits: (a) on a random basis as part of *continuous quality improvement* and/or monitoring activities; (b) as part of routine quality and/or billing audits; (c) as may be required by clients of ValueOptions; (d) in the course of performance under a given client contract; (e) as may be required by a given government or regulatory agency; (f) as part of periodic reviews conducted pursuant to *accreditation* requirements to which ValueOptions is or may be subject; (g) in response to an identified or alleged specific quality of care, professional competency or

professional conduct issue or concern; (h) as may be required by state and/or federal laws, rules and/or regulations; (h) in the course of claims reviews and/or audits; and/or (i) as may be necessary to verify compliance with the *provider agreement*.

ValueOptions treatment record standards and guidelines for *member* treatment record reviews conducted as part of quality management activities are set out in the quality management section of this *Resource Guide*.

Unless otherwise specifically provided in the *provider agreement*, access to and any copies of *member* treatment records requested by ValueOptions or designees of ValueOptions shall be at no cost.

Participating providers will grant access for *members* to the *member's* treatment records upon written request and with appropriate identification. *Participating providers* should review *member* treatment records prior to granting access to *members* to ensure that confidential information about other family members and/or significant others that may be referenced and/or included therein are redacted.

Confidentiality, Privacy & Security of Identifiable Health Information

Providers/participating providers are: (a) expected to comply with applicable federal and state privacy, confidentiality and security laws, rules and/or regulations, including without limitation the federal *Health Insurance Portability and Accountability Act* of 1996 (HIPAA) and the rules and regulations promulgated thereunder, and 42 C.F.R. Part 2; and (b) are responsible for meeting their obligations under these laws, rules and regulations, by implementing such activities as monitoring changes in the laws, implementing appropriate mitigation and corrective actions, and timely distribution of notices to patients(*members*), government agencies and the media when applicable. In the event that ValueOptions receives a *complaint* or becomes aware of a potential violation or breach of an obligation to secure or protect *member* information, ValueOptions will notify the *provider/participating provider* utilizing the general *complaint* process, and request that the *provider/participating provider* respond to the allegation and implement corrective action when appropriate. *Participating providers* must respond to such requests and implement corrective action as indicated in communications from ValueOptions.

Providers/participating providers and their business associates interacting with ValueOptions staff should make every effort to keep protected health information secure. If *provider/participating provider* does not use email encryption, ValueOptions recommends sending *protected health information* to ValueOptions through an inquiry in *ProviderConnect* or by secure fax.

Appointment and Availability Standards

Participating providers are expected to maintain established office/service hours and access to appointments with standards established by ValueOptions and/or as may be required by a given client of ValueOptions and/or specific government sponsored health benefit program.

Except as otherwise required by a specific client and/or government sponsored health benefit program for *providers* participating in networks available to their respective *members* and/or as delineated in the *provider agreement*, the following are standards of availability for appointments which *participating providers* are required to maintain:

Emergency: In an *emergency* situation, the *member* should be seen in person immediately or referred to appropriate *emergency service providers*. *Participating providers* who do not maintain twenty-four (24) hour coverage must 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, *participating providers* may elect to maintain a reliable recorded answering machine system through which *members* experiencing an *emergency* are given clear instructions about how to access immediate assistance after hours.

Emergent: In an *emergent* situation, the *member* should be seen within six (6) hours of the request for an appointment or referred to appropriate *emergency service providers*.

Urgent: In an *urgent* situation, the *member* must be offered the opportunity to be seen within twenty-four hours of a request for an appointment.

Routine: In a *routine* situation, a *member* must be offered the opportunity to be seen within 14 calendar days or 10 business days of a request for an appointment.

Out-of-Office Coverage

Participating providers should: (a) contact ValueOptions Customer Service at (800) 397-1630 during normal business hours Monday through Friday, 8 a.m. to 8 p.m. EST to inform ValueOptions of any unavailability or absence; and (b) notify ValueOptions National Network Operations at the address below in writing of coverage arrangements in advance of vacation, sabbatical, illness, maternity leave(where applicable), and/or any other situation when *participating provider* is unable to continue to treat ValueOptions *members* in active treatment. Such advance written notice should include: *participating provider's* name, licensure, practice locations affected, the reason for unavailability or absence and date range of unavailability or absence.

Mail to: ValueOptions, Inc. OR Fax to: (866) 612-7795
P.O Box 41055
Norfolk, VA 23541

Upon return, *participating providers* should contact ValueOptions Customer Service at (800) 397-1630 Monday through Friday, 8 a.m. to 8 p.m. EST and should notify ValueOptions National Network Operations at the address above in writing. Failure to contact ValueOptions within thirty (30) days of return may result in referral, *utilization management* and claims processing delays due to the 'inactive' status placed in ValueOptions' systems. Failure to respond to communications from ValueOptions related to 'inactive' or out-of-office versus 'active' status in ValueOptions' systems within the time period provided for in such communications may result in termination of participation in ValueOptions' provider networks.

Termination and Leave of Absence

If a *participating provider* remains on inactive status for longer than six months, a reminder is sent informing the provider of the expiration date and the disenrollment process for failure to respond to said notice.

Requests for Additional Information

To maintain in-network status, *participating providers* must furnish ValueOptions with any requested documentation or information promptly. Failure to do so may result in the *participating provider's* status being changed from active to inactive. Inactive providers are ineligible to receive referrals or reimbursement as *participating providers* for services rendered to *members* of ValueOptions' clients and/or *payors*.

[Back to Table of Contents](#)

Services to *Members*

Pursuant to the terms of the *provider agreement*, *participating providers* are contracted and credentialed to provide identified *covered services* to *members*. *Covered services* should be rendered in: (a) the same manner as services rendered to other patients; (b) accordance with accepted medical standards and all applicable state and/or federal laws, rules and/or regulations; and (c) a quality and cost-effective manner. *Participating providers* should note that coverage for behavioral health services and any limitations and/or exclusions as well any *pre-authorization* and/or *certification* requirements for non-emergency services vary by benefit plan.

Participating providers must:

- Verify *member* eligibility using ProviderConnect and verify benefits using NaviNet prior to rendering non-emergency services;
- Document other or third party health benefit coverage for *members* (Claims should be submitted to the primary *payor* initially.);
- *Preauthorize* or *certify* care where required in ValueOptions *policies and procedures* or the applicable *member* benefit plan, prior to rendering non-emergency services using ProviderConnect;
- Collect *member expenses* from the *member* prior to, at the time of, or subsequent to services being rendered;
- Provide continuous care for *members* or arrange for on-call coverage by other ValueOptions *participating providers*;
- Adhere to the *accessibility* and availability standards established by ValueOptions;
- Provide equal treatment to patients in a non-discriminatory manner, regardless of source of payment or coverage type or product;
- Update demographic, office and/or *participating provider* profile information promptly and in advance of changes using ProviderConnect;
- Notify ValueOptions of potential inpatient discharge problems;
- Advise *members* in writing of financial responsibility regarding services that are not covered, prior to rendering such service;
- Cooperate with ValueOptions in coordinating continued care through alternative agencies, other vendors or community resources when benefits end.
- Notify ValueOptions of *members* who may be candidates for potential Care Management;
- 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) conditions;
- Refer *members* to other *participating providers* when alternative or different mental health or substance abuse services are required;
- Submit claims on behalf of *members*;
- Upon written request by ValueOptions or third party *payors*, submit copies of *member* treatment records without charge (unless otherwise expressly provided for in the *provider agreement*);and
- Make resources available to *members* who require culturally, linguistically, and/or disability competent care. Such as, but not limited to, disability and language lines.

Emergency Services

In the event of an *emergency* admission, *participating providers* should notify ValueOptions as soon as reasonably practicable and in any event within 48 hours. *Retrospective review* of such admissions and associated services is subject to the terms of the *member's* benefit plan.

Referrals

Participating providers may receive referrals from several sources: (a) from *providers* and/or other *participating providers*; (b) through self-referral of *members*; (c) from ValueOptions; and/or (d) through an *EAP*.

Participating providers needing to refer a *member* for other or additional services should contact ValueOptions to identify what are *covered services* under the *member's* benefit plan and any limitations, exclusions and/or notice, *pre-authorization* or *certification* or *notification* requirements under their benefit plan.

On Track Outcomes

The ValueOptions *On Track* Outcomes Program is an outcomes management program designed to help *participating providers* incorporate *member*-reported feedback into outpatient psychotherapy sessions with the intended goal of improving outcomes. *On Track* supports *participating providers* as they help *members* stay “on track” in achieving their goals. This program is based on the completion of the Client Feedback Form (CFF) by the *member* during the course of receiving psychotherapy services. Participation by *members* is voluntary.

The CFF is designed to help *participating providers* assess clinical risk and monitor changes in symptoms and functioning as *members* receive services. *Participating providers* are asked to administer the CFF to *members* prior to the first, third, and every third session thereafter. The completed CFF should be reviewed by the *participating provider* and faxed to the designated toll-free *On Track* facsimile number for analysis. Scored and analyzed results generally are available online within one (1) business day. *On Track* provides *member*-specific tracking of progress in comparison to normative benchmarks, uses predictive modeling to identify potential high risk cases, and generates reports on aggregate case-mix adjusted provider outcomes. ValueOptions clinical staff may conduct outreach calls on particularly high risk cases.

Participating providers who are logged into *ProviderConnect* can connect directly to their *On Track* tools by using the link under ‘Clinical Support Tools’ on the *On Track* program home page. A separate *On Track* user ID and password are not needed. A personal, secure web page is available for each *participating provider* to view CFF results for *members* under their care. Detailed information about the *On Track* program, personalized copies of the CFF, and information for *members* can also be accessed here.

Coordination with Primary Care/Treating Providers

As part of care coordination activities, *participating providers* should identify all *providers/participating providers* involved in the medical and/or behavioral health care and treatment of a *member*. Subject to any required consent or *authorization* from the *member*, *participating providers* should coordinate the delivery of care to the *member* with these *providers/participating providers*. ValueOptions consent forms are available through the *ValueOptions.com* website.

Continuation following Provider Agreement Expiration or Termination

Non-renewal and termination of the *provider agreement* is the process by which the *provider agreement* is not renewed at the end of the identified period of time and accordingly ends by its own terms, or the *provider agreement* is terminated as provided for in the terms of the *provider agreement*.

All notices of non-renewal and/or termination of the *provider agreement* should be in writing and in accordance with the applicable terms of the *provider agreement*.

If a *participating provider* chooses to resign from the network and voluntarily surrender participation status, the *participating provider* must send ValueOptions written notice of such request and/or notice of termination of the *provider agreement* pursuant to the without cause termination provisions of the *provider agreement* (if any). ValueOptions will send the *participating provider* written acknowledgement of receipt of the *participating provider's* written request/notice and confirmation of the effective date of disenrollment/termination consistent with the provisions of the *provider agreement*. *Providers* who resign from network or voluntarily/involuntarily terminate the *provider agreement* are not eligible for re-application for six (6) months following the effective date of disenrollment/termination. Exceptions to the six (6) month timeframe may be considered in certain situations.

The effective date of non-renewal or termination of the *provider agreement* is that date: (a) identified in the notice of non-renewal or termination of the *provider agreement* and consistent with the end of the specific notice period; or (b) the date mutually agreed upon in writing by the *participating provider* and ValueOptions.

On or before the effective date of non-renewal or any termination of the *provider agreement*, *participating providers* must provide ValueOptions with a list of *members* for whom the *participating provider* has rendered services in the six (6) month period prior to the effective date of non-renewal or any termination of the *provider agreement*.

Participating providers must continue to provide *covered services* to *members* following the non-renewal or termination of the *provider agreement* pursuant to the terms of the *provider agreement* and for such time period(s) as are set out in the *provider agreement* or as required by government regulations. Payment for such *covered services* rendered to *members* following non-renewal or termination will be at the rates in the *provider agreement*.

Fraud, Waste and Abuse

ValueOptions interacts with employees, clients, vendors, *providers/participating providers* and *members* using standard clinical and business ethics seeking to establish a culture that promotes the prevention, detection and resolution of possible violations of laws and unethical conduct. In support of this, ValueOptions' compliance and anti-fraud plan was established to prevent and detect *fraud*, waste or abuse in the behavioral health system through effective communication, training, review and investigation. The plan, which includes ValueOptions' code of conduct, is intended to be a systematic process aimed at monitoring of operations, subcontractors and *providers/participating providers* compliance with applicable laws, regulations, and contractual obligations, as appropriate. *Participating providers* are required to comply with provisions of ValueOptions' code of conduct where applicable, including without limitation cooperation with claims billing audits, post-payment reviews, benefit plan oversight and monitoring activities, government agency audits and reviews, and participation in training and education. ValueOptions' code of conduct is accessible on the *ValueOptions.com website*.

[Back to Table of Contents](#)

Horizon Behavioral Health Program Complaints, Grievances & Appeals

The ValueOptions *complaint*, *grievance* and *appeal* processes provide an effective method and dependable problem resolution procedure for the informal resolution of *participating provider complaints*, issues, concerns or disputes that may arise related to the credentialing/re-credentialing process, *medical necessity* adverse determinations, administrative denials, claims processing and payment or denial of claims, and otherwise related to the *provider agreement*.

Information about the process for *appeals* related to credentialing and/or re-credentialing decisions is set out in the *appeals* section of this *Resource Guide*.

Information about the process for *appeals* of adverse determinations is set out in the *appeals* section of this *Resource Guide*.

General Complaints and Grievances

Complaints regarding issues related to performance under the *provider agreement* (e.g. *service complaints*, *complaints* about ValueOptions *policies and procedures* or the policies and procedures applicable to a specific client benefit plan or government sponsored health benefit program¹) should be directed to the Horizon Behavioral Health Customer Service Department at 1-800-626-2212, Monday through Friday, between 8:00 a.m. and 8:00 p.m. EST or in writing to:

Horizon BCBSNJ
Horizon Behavioral Health
Attention: Complaints
P.O. Box 783
Latham, NY 12110

Horizon Behavioral Health will acknowledge receipt of *participating provider complaints* verbally or in writing, and thereafter will investigate and attempt to reach a satisfactory resolution of the *complaint* within thirty (30) calendar days of receipt of the *complaint*. Horizon Behavioral Health will notify the *participating provider* verbally or in writing of the proposed resolution to the *complaint*, along with the procedure for filing an appeal (if applicable) should the provider/hospital not be satisfied with the proposed resolution.

[Back to Table of Contents](#)

Claims Procedures

Member Expenses

Member expenses due from the *member* for *covered services* are determined by the *member's* benefit plan. Detailed information about the amount of *member expenses* due for inpatient, outpatient or *emergency covered services* can be obtained by viewing a *member's* benefits on NaviNet. *Participating providers* are encouraged to contact Horizon Behavioral Health for questions regarding *member expenses*.

It is the responsibility of the *participating provider* to collect *member expenses* due to the *participating provider* for *covered services* rendered.

Preauthorization, Certification or Notification

Preauthorization, certification or notification requirements vary from plan to plan. *Participating providers* must determine if such requirements exist prior to the provision of non-emergency services to *members*. Information regarding ValueOptions' *policies and procedures* on *authorization, certification or notification* is located in the *utilization management*/review section of this *Resource Guide*. *Participating providers* may not bill, charge or seek reimbursement or a deposit from *members* for services determined not to be *medically necessary*.

Providers/participating providers may verify *member* eligibility, submit and review *authorization/certification* requests, and view *authorizations/certifications* online through ProviderConnect on the *ValueOptions.com website*.

No Balance Billing

Participating providers may not balance bill *members* for *covered services* rendered. This means that the *participating provider* may not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any other recourse against a member or any other person acting on a member's behalf (other than Horizon), for services provided pursuant to their provider agreement. Members should also not be billed for services or supplies for which Horizon provides benefits.

Claim Submission Guidelines

All behavioral health claims should be submitted electronically to Horizon according to Horizon's electronic claims processing procedures. Please refer to the Horizon Training Manual for information on procedures related to claim submission and inquiries.

Utilization Management

The ValueOptions *utilization management* program encompasses management of care from the point of entry through discharge using objective, standardized, and widely-distributed clinical protocols and outlier management programs. Intensive *utilization management* activities may apply for high-cost, highly restrictive levels of care and cases that represent clinical complexity and risk. *Participating providers* are required to comply with *utilization management policies and procedures* and associated review processes.

Examples of review activities included in ValueOptions' *utilization management* program are determinations of *medical necessity, preauthorization, certification, notification, concurrent review, retrospective review, care/case management, discharge planning and coordination of care.*

The ValueOptions *utilization management* program includes processes to address: (a) easy and early access to appropriate treatment; (b) working collaboratively with *participating providers* in promoting delivery of quality care according to accepted best-practice standards; (c) addressing the needs of special populations, such as children and the elderly; (d) identification of common illnesses or trends of illness; (e) identification of high-risk cases for intensive care management; and (f) prevention, education and outreach. Objective, scientifically-based clinical criteria and treatment guidelines, in the context of *provider* or *member* supplied clinical information, guide the *utilization management* processes.

Prior to beginning a course of treatment, *providers/participating providers* must contact ValueOptions by using ProviderConnect, the preferred method, to verify *member* eligibility and obtain *authorization* or *certification* (where applicable). Providers/participating providers can also verify eligibility and benefits via NaviNet.

In order to verify *member* eligibility, the *provider/participating provider* will need to have the following information available: (i) the patient's name, date of birth and *member* identification number; and should have available (ii) the insured or covered employee's name, date of birth and *member* identification number; and (iii) information about other or additional insurance or health benefit coverage. Based on the most recent data provided by employer/benefit plan sponsor, benefit plan administrator and/or where applicable the sponsoring government agency, ValueOptions will: (1) verify *member* eligibility; (2) identify benefits and associated *member expenses* under the *member's* benefit plan; and (3) identify the authorization or certification procedures and requirements under the *member's* benefit plan. Note: Verification of eligibility and/or identification of benefits and *member expenses* are not *authorization* or *certification* or a guarantee of payment.

Healthcare Effectiveness Data and Information Set (HEDIS®)

On an annual basis, ValueOptions participates with Horizon BCBSNJ in the collection of Healthcare Effectiveness Data and Information Set (HEDIS) data. HEDIS is a tool used by many of America's health plans to measure

performance on important dimensions of care and service. HEDIS consists of 80 measures across 5 domains of care and is maintained by the *National Committee for Quality Assurance (NCQA)*. Only a few of these measures pertain to behavioral health, but over the last few years increasing attention has been paid to developing new measures for behavioral health.

Participating providers play a critical role in ValueOptions HEDIS measure performance. The behavioral health indicators primarily address either the number or the timeliness of visits following a diagnosis of certain behavioral health disorders or treatment at specific levels of care. *Participating providers* should be aware of the standards set by these measures and must document appropriately in *members'* treatment records.

Beginning with HEDIS reporting year 2014, measurement year 2013, NCQA requires organizations to substantiate by documentation from the member's health record all nonstandard supplemental data that is collected to capture missing service data not received through claims, encounter data, laboratory result files, and pharmacy data feeds. ValueOptions may request proof of service documentation from the member's health record that indicates the service was received. All proof-of-service documents must include all the data elements required by the measure. ValueOptions has a process for data collection and integration of outpatient and inpatient claims, demographic data such as member name, date of birth (DOB) electronic health record and pharmacy. Additional data elements that are collected and integrated include, but are not limited to, practitioner type, date and place of service, diagnosis, date of test result, test result value or finding. Requested proof-of-service documents must be mailed, faxed, or otherwise delivered by the provider to the entity contacting the provider for the information. Permitted examples are: super-bills, lab reports, radiology reports, sections of the member's legal health record that show the service or assessment (documentation in the legal health record must be recorded, signed and dated by the provider).

Below is a brief description of the HEDIS measures that apply to the behavioral health field and the timeframes and numbers of sessions associated with each:

1. Follow-up after Hospitalization for Mental Illness

This measure is described as the percentage of discharges for *members* 6 years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 7 and/or 30 calendar days of discharge.

The critical pieces of this measure for *providers/participating providers* are:

Inpatient facilities need to:

- Use accurate diagnoses when submitting claims for inpatient treatment. If the diagnosis on admission is a mental health diagnosis but subsequent evaluation during the stay confirms that the primary diagnosis is substance abuse, please use the substance abuse diagnosis on the claim submitted at discharge.
- Assist in scheduling or ensure that follow-up visits are within seven (7) calendar days of discharge. **NOTE:** It is important to notify the *provider/participating providers* that the appointment is post hospital discharge and that an appointment is needed in seven (7) calendar days.

Outpatient providers/participating providers need to make every attempt to schedule appointments within 7 calendar days for *members* being discharged from inpatient care. *Providers/participating providers* are encouraged to contact those *members* who are "no show" and reschedule another appointment. Claims for these visits should be submitted in a timely fashion.

2. Initiation and Engagement of Alcohol and other Drug Use Treatment

This measure calculates two rates using the same population of *members* with Alcohol and Other Drug (AOD) use:

Initiation of AOD Use Treatment: The percentage of adults diagnosed with AOD Use who initiate treatment through either:

An inpatient AOD admission, or

An outpatient service for AOD (that can include an ER visit) AND an additional AOD service within 14 calendar days

Engagement of AOD Treatment: An intermediate step between initially accessing care and completing a full course of treatment. This measure is designed to assess the degree to which the *members* engage in treatment with two (2) additional AOD services within 30 calendar days after initiation phase ends. The services that count as additional AOD services include IOP, Partial Hospital, or outpatient treatment billed with CPT 4 or revenue codes associated with substance abuse treatment.

3. Antidepressant Medication Management (AMM)

The components of this measure assess different facets of pharmacological management of depression.

Optimal Practitioner Contacts for Medication Management: This process measure assesses the adequacy of clinical management of new treatment episodes for adult *members* with a major depressive disorder.

The measure is defined as the percentage of *members*, 18 years of age and older as of April 30th of the measurement year, who were diagnosed with a new episode of depression and treated with antidepressant medication, and who had at least three follow-up contacts with a non-mental-health practitioner or mental health practitioner coded with a mental health diagnosis during the 84-day (12-week) Acute Treatment Phase.

At least one of the three follow-up contacts must be with a prescribing practitioner (e.g., licensed physician, physician assistant or other practitioner with prescribing privileges).

Effective Acute Phase Treatment: This intermediate-outcome measure assesses the percentage of adult *members* initiated on an antidepressant drug who received a continuous trial of medication treatment during the Acute Treatment Phase.

The percentage is determined by the number of *members*, 18 years of age and older as of April 30th of the measurement year, who were diagnosed with a new episode of major depression, were treated with antidepressant medication and remained on an antidepressant drug during the entire 84-day (12-week) Acute Treatment Phase.

Effective Continuation Phase Treatment: This intermediate-outcome measure assesses the effectiveness of clinical management in achieving medication compliance and the likely effectiveness of the established dosage regimen.

The percentage is determined by the number of *members*, 18 years of age and older as of April 30th of the measurement year, who were diagnosed with a new episode of major depression and treated with antidepressant medication and who remained on an antidepressant drug for at least 180 days (6 months).

4. Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication: Includes continuation and maintenance.

The following two rates in the measure assess follow-up care for children prescribed a medication to treat ADD or ADHD. Examples of the antidepressant medications included in this measure are:

- Tricyclic antidepressants (TCA) and other cyclic antidepressants
- Selective serotonin reuptake inhibitors (SSRI)
- Monoamine oxidase inhibitors (MAOI)
- Serotonin-norepinephrine reuptake inhibitors (SNRI), and
- Other antidepressants

Initiation Phase: Defined as the percentage of *members*, 6–12 years of age as of the prescription start date, with an ambulatory prescription dispensed for ADHD/ADD medication and who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

Continuation and Maintenance (C&M) Phase: Defined as the percentage of *members*, 6–12 years of age as of the prescription start date, with an ambulatory prescription dispensed for ADHD/ADD medication who remained on the medication for at least 210 days and had at least two additional follow-up visits with a practitioner within 270 days (9) months after the Initiation Phase ends.

5. Depression Utilization of the PHQ-9 Tool: Measure Assess Use of the PHQ-9 for Monitoring Treatment Progress in Members with Diagnosis of Depression (Performance Measure with NQF methodology)

6. Diabetes Screening for People with Bipolar Disorder or Schizophrenia Who Are Using Antipsychotic Medications (SSD)

This measure is described as the percentage of members 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

This measure is described as the percentage of members 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

7. Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC): *Non-behavioral health measure*

This measure is described as the percentage of members 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

8. Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)*

This measure is described as the percentage of members 19–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

9. Plan All-Cause Readmissions (PCR)

For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute

readmission. Data are reported in the following categories:

1. Count of Index Hospital Stays (IHS) (denominator).
2. Count of 30-Day Readmissions (numerator).
3. Average Adjusted Probability of Readmission.

New & Emerging Technologies

ValueOptions recognizes the need for knowledge of emerging technologies to provide access to optimum care for *members*. ValueOptions evaluates these technologies in terms of their overall potential benefits to *members* and in some instances recommends these technologies to clients for inclusion in their respective benefit packages. Examples of new technologies are psychotropic medications or new, approved uses of current medications, innovative community service programs and new approaches to provision of psychotherapy and treatment. ValueOptions has established committees that conduct formal reviews of potential new technologies. The effectiveness of new service technologies will be considered in *medical necessity* decisions.

In addition, ValueOptions supports providers to use technologies to improve convenience and appropriate use of health benefits by members. An example is the ability of members to schedule appointments through a secure web-site, allow members access to their electronic medical record so they can keep track of personal health information and other types of technologies such as automatic reminders to refill medications or to keep appointments.

Treatment Planning

Providers/participating providers must develop individualized treatment plans that utilize assessment data, address the *member's* current problems related to the behavioral health *diagnosis*, and actively include the *member* and significant others, as appropriate, in the treatment planning process. *CCMs* review the treatment plans with the *providers/participating providers* to ensure that they include all elements required by the *provider agreement*, applicable government program, and at a minimum:

- a. Specific measurable goals and objectives;
- b. Reflect the use of relevant therapies;
- c. Show appropriate involvement of pertinent community agencies;
- d. Demonstrate discharge planning from the time of admission; and
- e. Reflect active involvement of the *member* and significant others as appropriate.

Providers/participating providers are expected to document progress toward meeting goals and objectives in the treatment record and to review and revise treatment plans as appropriate.

Clinical Review Process

Provider/participating provider cooperation in efforts to review care prospectively is an integral part of care coordination activities and is subject to the terms of the *member's* benefit plan and applicable state and/or federal laws and/or regulations. ValueOptions may request clinical information at various points in treatment to ensure the ongoing need for care and treatment that is appropriate and effective in improving health outcomes for members.

In all cases, *providers/participating providers* are encouraged to contact ValueOptions prior to initiating any treatment to verify *member* eligibility and to clarify what the *authorization* or *certification* requirements are, if any, for the proposed treatment.

Coverage and payment for services proposed for and/or provided to *members* for the identification or treatment of a *member's* condition or illness is conditioned upon *member* eligibility, the benefits covered under the *member's* benefit plan

at the time of service, and on the determination of *medical necessity* of such services and/or treatment. Overpayments made as a result of a change in eligibility of a *member* are subject to recovery (see Overpayment Recovery section).

Subject to verification of eligibility under the *member's* benefit plan, upon request for *authorization* or *certification* of services, the *Clinical Care Manager (CCM)* gathers the required clinical information from the *provider/participating provider*, references the appropriate clinical criteria for the services and/or *level of care*, and determines whether the services and treatment meets criteria for *medical necessity*. The *CCM* may *authorize* or *certify levels of care* and treatment services that are specified as under the *member's* benefit plan (e.g., acute inpatient, residential, partial hospitalization, intensive outpatient, or outpatient). *Authorizations* or *certifications* are for a specific number of services/units of services/days and for a specific time period based on the *member's* clinical needs and provider characteristics.

Prior to initial determinations of *medical necessity*, the *member's* eligibility status and coverage under a benefit plan administered by ValueOptions should be confirmed. If eligibility information is not available in non-emergency situations, a *CCM* may complete a screening assessment and pend the *authorization/certification* awaiting eligibility verification. *CCMs* will work with *members* and *providers/participating providers* in situations of *emergency*, regardless of eligibility status.

If a *member's* benefits have been exhausted or the *member's* benefit plan does not include coverage for behavioral health services, the *CCM*, in coordination with the *provider/participating provider* as appropriate, will provide the *member* with information about available community support services and programs, such as local or state-funded agencies or facilities, that might provide sliding scale discounts for continuation in outpatient therapy, or where available under the *member's* benefit plan explore benefit exchanges with the client plan.

When a *provider/participating provider* requests a *retrospective review* for services previously rendered, ValueOptions will first determine whether such a *retrospective review* is available under the *member's* benefit plan and request the reason for the *retrospective review* (e.g., *emergency* admission, no presentation of a ValueOptions *member* identification card, etc.). In cases where a *retrospective review* is available, services will be reviewed as provided for in this *Resource Guide*. In cases where a *retrospective review* is not available under the *member's* benefit plan and/or and where the *provider/participating provider* fails to follow administrative process and requirements for *authorization, certification* and/or *notification*, the request for *retrospective review* may be administratively denied. Subject to any client, government sponsored health benefit program and/or benefit plan specific requirements, the chart below references the standard timeframes applicable to the type of review request.

Standard Determination Timeframes : These are not NJ TAT standards, you need to get those		
Request Type	Timing	Determination
Prospective <i>Urgent</i>	Prior to treatment	Within 72 hours
Prospective Non-urgent	Prior to treatment	Within 15 calendar days (14 for contracts governed by CMS)
Concurrent <i>Urgent</i>	>24 hours of <i>authorization</i> expiration	Within 24 hours
Concurrent <i>Urgent</i>	<24 hours from <i>authorization</i> expiration	Within 72 hours
Concurrent Non-Urgent	Prior to <i>authorization</i> term	<u>Reverts to Prospective</u> , so within 72 hours/15 calendar days (14 for contracts governed by CMS)
Retrospective	After services	Within 30 calendar days

ValueOptions' procedures for *authorization*, *certification* and/or *notification* apply to services and treatment proposed and/or previously rendered in instances where the *member* benefit plan administered by ValueOptions is primary and instances where the *member* benefit plan administered by ValueOptions is secondary.

ValueOptions, at times, may administer both primary and secondary benefit plans of a given *member*. To avoid possible duplication of the review process in these cases, *providers/participating providers* should notify ValueOptions of all pertinent employer and other insurance information for the *member* being treated.

Note: Failure to follow *authorization*, *certification* and/or *notification* requirements, as applicable, may result in administrative denial/non-certification and require that the *member* be held harmless from any financial responsibility for the *provider's/participating provider's* charges.

Definition of Medical Necessity

Unless otherwise defined in the *provider agreement* and/or the applicable *member* benefit plan and/or the applicable government sponsored health benefit program, ValueOptions' reviewers, *Clinical Case Managers*, *Peer Advisors*, and other individuals involved in ValueOptions' *utilization management* processes use the following definition of *medical necessity* or *medically necessary* treatment in making *authorization* and/or *certification* determinations:

- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (current ICD or DSM) that threatens life, causes pain or suffering, or results in illness or infirmity
- Expected to improve an individual's condition or level of functioning
- Individualized, specific and consistent with symptoms and *diagnosis*, and not in excess of patient's needs
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications
- Reflective of a level of service that is safe, where no equally effective, more conservative and less costly treatment is available
- Not primarily intended for the convenience of the recipient, caretaker or *provider/participating provider*
- No more intensive or restrictive than necessary to balance safety, effectiveness and efficiency
- Not a substitute for non-treatment services addressing environmental factors

Clinical Criteria

The clinical criteria used by ValueOptions to make admission, *level of care* and continuing treatment decisions reflect ValueOptions' philosophy and clinical values. To determine the appropriate *level of care* during a review the *Clinical Care Manager (CCM)* evaluates the pertinent clinical information relative to the *levels of care* criteria. These clinical criteria are assessed, revised where necessary and approved and/or adopted at least annually by the ValueOptions Corporate Executive Medical Management Committee (EMMC) and *Clinical Advisory Committees*. Sources for various clinical criteria include:

- The American Psychiatric Association
- The American Psychological Association
- The American Academy of Psychiatrists in Alcoholism and Addictions
- The American Academy of Child and Adolescent Psychiatry
- The American Society of Addiction Medicine
- TriCare
- Consumer and family empowerment organizations (e.g., state-based Consumer Councils; National Mental Health Consumers' Self-Help Clearing House; National Alliance for the Mentally Ill; Federation of Families for Children's Mental Health)
- International Association of Psychosocial Rehabilitation Services
- InterQual
- State specific regulatory requirements including Texas Administrative Code, Subchapter HH regarding Standards for Reasonable Cost Control & Utilization Review for Chemical Dependency Treatment Centers
- The National Institutes of Health
- The National Institute on Alcohol Abuse and Alcoholism
- The National Institutes of Drug Abuse
- The Department of Health and Human Services' Center for Substance Abuse Treatment
- Standard psychiatric texts: and
- Current Publications in professional journals and books.
- Criteria from National peer organizations including managed care organizations (MCO) and behavioral health organizations (BHO)
- The Diagnostic and Statistical Manual IV-TR
- The American Accreditation HealthCare Commission/URAC standards
- The *American Society of Addiction Medicine standards (ASAM)*
- The American Society of Addiction Medicine PPC-2R2R Criteria
- Health Management Strategies International Mental Health Review Criteria
- Discussions with senior consultants in the field
- Various criteria sets from other *utilization management* entities and third party *payors*

ValueOptions uses its own clinical criteria for mental health, which is available by clicking [here](#), and substance use criteria based on ASAM PPC-2 criteria published by the American Society for Addiction Medicine (ASAM). Use of the ASAM criteria is required in some jurisdictions. To order a copy of the ASAM criteria, please go to the following Web site: www.asam.org/PatientPlacementCriteria.html.

Treatment Guidelines

In addition to clinical criteria, ValueOptions has a set of Diagnosis-Based Treatment Guidelines. These guidelines are used in collaboration with *providers* to help guide appropriate and clinically effective care for a variety of complex psychiatric conditions. These guidelines represent standards of best practice for treating these complex conditions and can be referred to by *Clinical Care Managers (CCM)* and *Peer Advisors (PA)* during reviews. ValueOptions seeks input from *participating providers*, consultants, and other expert clinicians to develop some of the guidelines; however in most instances ValueOptions adopts established and/or published guidelines such as those developed by the American Psychiatric Association (e.g., Bipolar, Major Depression, Schizophrenia, Eating Disorder and ECT). Information about and access to Treatment Guidelines used by ValueOptions is available on the *ValueOptions.com website*. You can access the Treatment Guidelines by clicking [here](#).

ValueOptions' Care Management System

Members and *participating providers* may access the ValueOptions care management system through any of the following avenues:

- 24-hour toll-free emergency care/clinical referral line
- Direct registration/certification of care through *ProviderConnect* for participating providers
- Direct *authorization/certification* of all *levels of care* through referral by a ValueOptions' *Clinical Care Manager (CCM)*
- Emergency services through freestanding psychiatric hospitals, medical hospitals with psychiatric units, emergency rooms or crisis response teams

If a call is received from a *member* requesting a referral and/or information about *participating providers* in the *member's* location, *CCMs* may conduct a brief screening to assess whether there is a need for *urgent* or *emergent* care. Referrals are made to *participating providers*, taking into account *member* preferences such as geographic location, hours of service, cultural or language requirements, ethnicity, type of degree the *participating provider* holds and gender. Additionally, the *member* may require a clinician with a specialty such as treatment of eating disorders. In all cases, where available, the *CCM* will assist in arranging care for the *member*. The name, location and phone number of at least three *participating providers* will be given to the member.

Clinical Care Manager Reviews

ValueOptions' *Clinical Care Managers (CCMs)* base reviews on established criteria adopted by ValueOptions and/or ASAM criteria. *CCMs* are trained to match the needs of *members* to appropriate services, *levels of care*, treatment and length of stay, and community supports. This requires careful consideration of the intensity and severity of clinical data presented, with the goal of quality treatment in the least restrictive environment. The clinical integrity of the *utilization management* program seeks to provide that *members* who present for care are appropriately monitored and that comprehensive reviews of all *levels of care* are provided. Those cases that appear to be outside of best practice guidelines or appear to be treatment outliers are referred for specialized reviews. These may include evaluation for intensive care management, clinical rounds, *peer advisor* review or more frequent *CCM* review.

CCMs obtain clinical data from the *provider/participating provider* or designee relating to the need for care and treatment planning. The *CCM* evaluates this information and references applicable clinical criteria to determine *medical necessity* of the requested *level of care* or service. Where appropriate, care is *pre-certified* for a specific number of services/days for a specific time period at a specific *level of care*, based on the needs of the *member*.

Except where disclosure of certain information is expressly prohibited by or contrary to applicable state or federal laws or regulations, *participating providers* must be prepared to provide ValueOptions with the following information at the time of the review, as necessary and appropriate:

- Demographics
- *Diagnosis* (current DSM or ICD)
- Reason for admission/precipitant
- Suicidal/homicidal risk, including
 - ideation
 - plan
 - intent
 - psychotic/non-psychotic (e.g., command hallucinations, paranoid delusions)
- Substance use history
 - type
 - amount
 - withdrawal symptoms
 - vital signs
 - date(s) of initial use and last use
 - date(s) of periods of sobriety
- Other presenting problem/symptomatology description, if applicable
- Progress since admission (if *concurrent review*)
- Medical problems
 - medical history
 - organic cause of psychiatric symptoms/behaviors
 - medical problems which exacerbate psychiatric or substance use symptoms/behaviors
- Current medications
 - types(s)
 - dosage(s)
 - date(s)
 - duration
 - response
 - provider(s)
- Primary care physician (PCP) interface, if applicable
- Other behavioral health care provider interface, if applicable
- General level of functioning
 - sleep, appetite
 - mental status
 - ADLs (Activities of Daily Living)
- Psychological stressors and supports
 - socioeconomic
 - family
 - legal
 - social
 - abuse, neglect, domestic violence (as appropriate)
- Response to previous treatment
 - previous treatment history, most recent treatment, past treatment failures
 - relapse/recidivism, motivation for treatment
 - indications of compliance with treatment recommendations
- Treatment plan
 - estimated length of stay
 - treatment goals
 - specific planned interventions
 - family involvement
 - precautions for specific risk behaviors

- educational component for regulatory compliance and substance abuse situations
- Discharge plan
 - aftercare required upon discharge
 - barriers to discharge

Inpatient Care

All inpatient care will be subject to the review requirements described in this section. Prior to non-emergency admission and/or beginning treatment, the *provider/participating provider* must contact ValueOptions:

- For *notification*
- To confirm benefits and verify *member* eligibility
- To provide clinical information regarding the *member's* condition and proposed treatment
- For *authorizations* or *certifications*, where required under the *member's* benefit plan

ProviderConnect is available twenty four (24) hours a day, seven (7) days a week (excluding scheduled maintenance and unforeseen systems issues) and should be utilized to verify eligibility and provide notification and clinical information as appropriate. *Providers/participating providers* can secure copies of the *authorization/certification* requests at time of submission for their records. The web portal can be utilized for *concurrent reviews* and discharge reviews as well as initial or precertification reviews.

Clinical Care Managers (CCMs) and/or Referral Line Clinicians are available seven (7) days a week, twenty-four (24) hours a day, three hundred sixty-five (365) days a year to provide assessment and referral and conduct *authorization* or *certification* reviews.

Where *authorization, certification* or *notification* is required by the *member's* benefit plan and unless otherwise indicated in the *provider agreement, providers/participating providers* should contact ValueOptions within 48 hours of any *emergency* admission for *notification* and/or to obtain any required *authorization* or *certification* for continued stay.

If prior to the end of the initial or any subsequent *authorization* or *certification*, the *provider/participating provider* proposes to continue treatment, the *provider/participating provider* must contact ValueOptions for a review and recertification of *medical necessity*. It is important that this review process be completed more than 24 hours *prior* to the end of the current *authorization* or *certification* period.

Continued stay reviews: (a) focus on continued severity of symptoms, appropriateness and intensity of treatment plan, *member* progress and discharge planning; and (b) involve review of treatment records and discussions with the *provider/participating provider* or appropriate facility staff, *EAP* staff or other behavioral health *providers* and reference to the applicable clinical criteria. In instances where the *continued stay review* by a *CCM* does not meet clinical criteria and/or where questions arise as to elements of a treatment plan or discharge plan, the *CCM* will forward the case file to a *Peer Advisor* for review.

Note: Horizon behavioral health providers should utilize ProviderConnect for all authorization requests. Telephonic reviews are available.

Discharge Planning

Discharge planning is an integral part of treatment and begins with the initial review. As a *member* is transitioned from inpatient and/or higher *levels of care*, the *Clinical Care Manager (CCM)* will review/discuss with the *provider/participating provider* the discharge plan for the *member*. The following information may be requested and must be documented:

- Discharge date
- Aftercare date
 - Date of first post-discharge appointment (must occur within 7 days of discharge)
 - With whom (name, credentials)
 - Where (*level of care*, program/facility name)
- Other treatment resources to be utilized: types, frequency
- Medications
 - Patient/family education regarding purpose and possible side effects
 - Medication plan including responsible parties
- Support systems
 - Familial, occupational and social support systems available to the patient. If key supports are absent or problematic, how has this been addressed
 - Community resources/self-help groups recommended (note purpose)
- *EAP* linkage
 - if indicated (e.g., for substance abuse aftercare, workplace issues, such as Return-to- Work Conference, enhanced wrap-around services) indicate how this will occur
- Medical aftercare (if indicated, note plan, including responsible parties)
- Family/work community preparation
 - Family illness education, work or school coordination, (e.g., *EAP* and Return-to-Work Conference) or other preparation done to support successful community reintegration. Note specific plan, including responsible parties and their understanding of the plan.

Case Management Services for select patients who meet high-risk criteria

As part of the case management program at ValueOptions, we offer assistance in:

- Discharge planning
- Assessment and integration of service for on-going needs
- Coordination with behavioral health services
- Collaboration with healthcare providers and care givers
- Providing information about what benefits might be available
- Medication education and monitoring

Hospitals may be asked for assistance in enrolling patients in case management during inpatient admissions.

When requested, please:

1. Have the patient complete the *authorization* form, with help if needed.
2. Send the *authorization* to ValueOptions by faxing it to the number on the form.
3. Schedule a discharge appointment within 7 days after discharge. If you need help with getting an appointment within 7 days, please contact ValueOptions.

Adverse Clinical Determination/ Peer Review

If a case does not meet *medical necessity* criteria at the requested *level of care*, the *CCM* attempts to discuss the *member's* needs with the *provider/participating provider* and to work collaboratively with the *provider/participating provider* to find an appropriate alternative level of care. If no alternative is agreed upon, the *CCM* cannot deny a request for services. Requests that do not appear to meet *medical necessity* criteria or present quality of care issues are referred to a *peer advisor* for second level review. It is important to note that only a doctoral level *peer advisor* can clinically deny a request for services. The *peer advisor* reviews the available information and may elect to conduct a Peer-to-Peer Review, which involves a direct telephone conversation with the attending or primary *participating provider* to discuss the case. Through this communication, the *peer advisor* may obtain clinical data that were not available to the *CCM* at the time of the review. This collegial clinical discussion allows the *peer advisor* the opportunity to explore alternative treatment plans with the *provider/participating provider* and to gain insight into the attending provider's anticipated goals, interventions and timeframes. The *peer advisor* may request more information from the *provider/participating provider* to support specific treatment protocols and ask about treatment alternatives.

When an adverse determination is made, the treating provider (and hospital, if applicable) is notified telephonically of the decision and asked to notify the *member*. Written notification of an adverse determination is issued to the *member*, *member* representative, practitioner, and facility within decision timeframes. If an adverse decision is rendered, the *provider/participating provider* has the right to speak with the *peer advisor* who made the adverse determination by calling ValueOptions at the toll free phone number of the *member's* plan. For substance abuse treatment of minors, ValueOptions follows federal and state guidelines regarding release of information in determining the distribution of adverse decision letters.

All written or electronic adverse determination notices include:

- a. The principal reason(s) for the determination not to certify,
- b. A statement that the clinical rationale (or copy of the relevant clinical criteria), guidelines, or protocols used to make the decision will be provided, in writing, upon request,
- c. Rights to and instructions for initiating an *appeal*, including the opportunity to request an expedited *appeal* if applicable for first level *appeals*, and information about the *appeal* process,
- d. The right to request an *appeal* verbally, in writing, or via fax transmission,
- e. The timeframe for requesting an *appeal*, and
- f. The opportunity for the *member*, *provider/participating provider* to submit, for consideration as part of the *appeals* process, written comments, documents, records, and other information relating to the case,
- g. The *member's* right to bring a civil action under the Employer Retirement Income Security Act of 1974 (ERISA), when applicable, and
- h. The right of the *provider/participating provider* to request a reconsideration within three (3) business days of receipt of the notice when a *medical necessity* denial is issued without a Peer-to-Peer conversation having taken place, or when an administrative denial is issued because of the failure of a *provider/participating provider* to respond to a request for Peer-to-Peer conversation within a specified timeframe.

Electroconvulsive Therapy

Prior to conducting *Electroconvulsive Therapy* (ECT), *providers/participating providers* must contact ValueOptions for *pre-certification* of such therapy. All pre-certification requests for ECT are reviewed by a physician.

Outpatient Services

Horizon behavioral health has created an outpatient model for professional and outpatient clinic services that focuses only on outlier cases. Providers are encouraged to use *On Track* and Treatment practice guidelines when performing

outpatient services involving professional and clinic services. Providers will be contacted if additional information is required for outpatient professional services.

Providers/participating providers should request any required *authorization* or certification for outpatient services by using the preferred electronic method, *ProviderConnect*. If the preferred method, *ProviderConnect*, is not available *providers/participating providers* should submit a ValueOptions *Outpatient Review* or other state required or approved *outpatient review* form (where applicable), or use the toll-free number for a telephonic review where applicable. In instances where a review does not meet clinical criteria and/or where questions arise as to elements of a treatment plan, the case file may be forwarded to a *Peer Advisor* for review.

Outpatient testing includes but is not limited to Psychological/developmental/neuropsychological testing. Neurobehavioral status exam require prior authorization. Providers must contact ValueOptions before rendering these services to members.

[Back to Table of Contents](#)

Appeal of Adverse Determinations

When authorized by the *member* and/or when a *member* assigns *appeal* rights in writing to a *participating provider*, the *participating provider* may *appeal* on behalf of the *member* adverse determinations (denials) made by ValueOptions. *Participating providers* must inform the *member* of adverse determinations and any *appeal* rights of which the *participating provider* is made aware.

Member appeal rights are limited to those available under the *member's* benefit plan, and may involve one or more levels of *appeal*.

Provider appeal rights are based upon the type of benefit plan the member is enrolled in and the provider contract. They may involve one or more levels of *appeal*.

While the number of *appeals* available is determined by the *member's* benefit plan, the type of *appeal*, 'administrative' or 'clinical', is based on the nature of the adverse determination. The *member's* care circumstances at the time of the request for *appeal* determine the category of *appeal* as *urgent*, non-urgent, or retrospective. The *member* benefit plan and applicable state and/or federal laws and regulations determine the timing of the *appeal* as expedited, standard, or retrospective. For example, if a *provider/participating provider* files a Level I *appeal* on behalf of a *member* in *urgent* care, the *appeal* is processed as an expedited *appeal*, even if the *member* is discharged prior to the resolution of the *appeal*.

Unless otherwise provided for in the *member* benefit plan, government sponsored health benefit program, or applicable state or federal law or regulation, the *provider/participating provider* and/or the *member* (or the *member's* authorized representative), has the right to file or request: (a) an initial or Level I *appeal* of an adverse determination for up to one hundred and eighty (180) calendar days from receipt of notice of the adverse determination; and (b) a second level or Level II *appeal* of an adverse determination for up to ninety (90) calendar days from receipt of notice of the Level I *appeal* determination, in those instances where a second level or Level II *appeal* is available to the *member*. Initial or Level I *appeals* may be made verbally, in writing, or via fax transmission. Unless otherwise provided for or restricted under the *member* benefit plan, government sponsored health benefit program, or applicable state or federal law or regulation, second level or Level II *appeals* may be made verbally, in writing, or via fax transmission.

The *member*, *member's* authorized representative, and/or the *provider/participating provider* may submit any information they feel is pertinent to the *appeal* request and all such information is considered in the *appeals* review, whether or not it was available to ValueOptions' reviewers during the initial determination.

The date of the request for an initial or Level I or Level II *appeal* of the adverse determination is considered the date and time the *appeal* request is received by ValueOptions.

Written notice of determinations for all Level I and Level II *appeals* of adverse determinations will be made to the *member* and the *provider/participating provider* where required by the *member* benefit plan, government sponsored health benefit program, and/or applicable state or federal laws or regulations.

Clinical Appeals

Clinical appeal reviews of adverse *medical necessity* determinations administered by ValueOptions are conducted by a *Peer Advisor* in the same profession and/or in a similar specialty as typically manages the behavioral health condition, procedure or treatment, as deemed appropriate, or a committee of practitioners having similar qualifications of a *Peer Advisor*. *Clinical appeal* reviewers are neither the individual who made the original adverse *medical necessity* determination, nor the subordinate of such an individual.

Written notice of Level I and Level II *clinical appeal* determinations upholding the original adverse determination (or Level I *appeal* where applicable), in whole or in part, will include: (a) the principal reason or reasons for the determination; (b) reference to the clinical criteria and/or guidelines used to be made available upon request; (c) the procedures for initiating the next step in the *appeal* process, if any; (d) the right of the *member* and/or the *provider/participating provider* to submit additional information in support of the next level of *appeal*, if any; and (e) where applicable information related to the *member's* right to file suit and/or to pursue other voluntary dispute options as required by ERISA, or provisions as may be required by applicable laws, regulations or government sponsored health benefits programs (e.g. Medicare Advantage or Managed Medicaid).

Level I (Initial): Standard Appeals - Upon being assigned a case for review of an adverse determination *clinical appeal*, a *Peer Advisor* will investigate the substance of the *appeal*, including aspects of the clinical care involved, and review of documents, records, or other information submitted with the request for the Level I *appeal*, regardless of whether such information was also submitted or considered in the original adverse determination and the applicable clinical criteria. The *Peer Advisor* will attempt to contact the *provider/participating provider* (or the clinical representative of facility or program *providers/participating providers*) directly to conduct a telephonic review as appropriate. Based on consideration of all pertinent information, including relevant clinical criteria and guidelines, the *Peer Advisor* will make a determination to reverse (i.e., overturn) the original adverse determination in whole or part, or to uphold the original adverse determination.

When an adverse determination *clinical appeal* review is conducted and completed telephonically, the *Peer Advisor* will verbally inform the *provider/participating provider* of the determination. If the determination is to reverse the original adverse determination, the *Peer Advisor* will identify the length of stay, *level of care* and/or number of service units or sessions determined to be *medically necessary*. If the determination is to uphold the adverse determination, the *Peer Advisor* includes any recommendations for treatment for which *medical necessity* could be confirmed and the procedure for following the next step in the *appeals* process, if any.

Expedited Appeals - An expedited *appeal* is a request to review an adverse determination concerning admission, continued stay, or other behavioral healthcare services for a *member* who

has received *urgent* services but has not been discharged from a facility, or when a delay in decision making might seriously jeopardize the life or health of the *member*. Only an initial or Level I *appeal* can be processed as an expedited *appeal*. ValueOptions follows the same determination procedures outlined above for standard *appeals*, but issues the decision and notification for all expedited *appeals* within 72 hours of the *appeal* request. Expedited *appeals* are conducted by a *Peer Advisor* not involved in the original adverse determination. Determinations are communicated by telephone on the same day as the determination, with written notification sent within the 72 hour timeframe.

Level II: Upon being assigned a case for review of an adverse determination *clinical appeal*, a *Peer Advisor* will investigate the substance of the *appeal*, including aspects of the clinical care involved, and review of documents, records, or other information submitted with the request for the Level II *appeal*, regardless of whether such information was also submitted or considered in the original adverse determination or the Level I *appeal* and the applicable clinical criteria. The *Peer Advisor* will attempt to contact the *provider/participating provider* (or the clinical representative of facility or program *providers/participating providers*) directly to conduct a telephonic review as appropriate. Based on consideration of all pertinent information, including relevant clinical criteria and guidelines, the *Peer Advisor* will make a determination to reverse (i.e., overturn) the Level I *appeal* determination in whole or part, or to uphold the original adverse determination and Level I *appeal* determination.

This level of *clinical appeal* involves a review of all pertinent clinical information by another *Peer Advisor* who has not been previously involved with the adverse determination, or a Level II Appeal Committee, depending on the *member's* benefit plan and what administrative activities have been delegated to ValueOptions by the client plan. When a Level II *clinical appeal* is conducted by a Level II Appeal Committee, in some circumstances and only where indicated in the notice of Level I *appeal* determination the *member* may have the right to appear before the Level II Appeal Committee.

Retrospective: A retrospective *clinical appeal* is one requested after the *member* has been discharged from the *level of care* or treatment service under consideration. Retrospective *clinical appeals* of adverse determinations require that the *provider/participating provider* send in specific sections of the treatment record for review. Retrospective *clinical appeal* determination notices are issued within the decision timeframe and contain the required information outlined above under ‘Standard Appeals’.

Administrative Appeals

Administrative appeal reviews of adverse determinations are conducted by the applicable local Engagement Center Vice President or their designee, or by an appeal committee. *Administrative appeal* reviewers are neither the individual who made the original adverse determination, nor the subordinate of such an individual.

The types and levels of *appeal*, as well as decision and notification requirements mirror those described above for *clinical appeals*.

Final Appeal Level

For those benefit plans that provide for a final stage of *appeal* (clinical or administrative) for the *member*, Horizon Behavioral Health will cooperate with the requirements of such final stage of *appeal* and where agreed upon with the client plan coordinate such final stage of *appeal*. Final stages of *appeal* may include reviews by an arbitration board, benefits committee, external review entities, state agency sponsored external review processes, and government sponsored health benefits program medical directors, or other review entities and/or processes. Information about and procedures for such final *appeal* level, if any, will be included in notice of *appeal* determination for the last level of *appeal* available before final *appeals*.

[Back to Table of Contents](#)

Quality Management/Quality Improvement

ValueOptions utilizes a *Continuous Quality Improvement (CQI)* philosophy through which ValueOptions directly or through its authorized designees, monitors and evaluates appropriateness of care and service, identifies opportunities for improving quality and access, establishes quality improvement initiatives, and monitors resolution of identified problem areas. This includes monitoring and evaluation of services performed by ValueOptions or its designees, as well as behavioral health services rendered by *providers* and *participating providers*.

ValueOptions' comprehensive Quality Management Program (QMP) includes Quality Management (QM) *policies and procedures* applicable to all *participating providers*, strategies and major activities performed to provide for consistency and excellence in the delivery of services, includes a program description, an annual work plan that includes goals and objectives and specific QM related activities for the upcoming year and evaluation of the effectiveness of those activities. *Participating providers* are responsible for adhering to the QMP and are encouraged to provide comments to ValueOptions regarding ongoing QMP activities.

QM Committees

The ValueOptions Executive Quality Council (EQC) has ultimate accountability for the oversight and effectiveness of the QMP. The Company Quality Council (CQC) is the body responsible for coordinating all national level Quality Management activities and providing oversight, direction, and consultation to the local QM Committees and any local ValueOptions Engagement Center specific quality management programs. Local ValueOptions Engagement Center QM Committees are responsible for oversight of the day-to-day operations of their specific quality management programs and communication of their activities and findings back to the CQC to be incorporated back into the QMP, as well as for reporting and oversight of local quality management activities in their Engagement Center.

In addition, certain functional areas within ValueOptions (e.g., Claims) maintain quality management programs specific to the activities and services performed. Quality programs within functional areas are responsible for coordinating their quality management programs with the QMP by communicating their findings and activities to the CQC to be incorporated into QMP.

The EQC reviews and approves the National QM Program Description, QM Program Evaluation, and QM Work plan at least annually and at the time of any revision. The CQC receives a quarterly summary of all QM activities included in the work plan.

Scope of the Quality Management Program

The ValueOptions National Quality Management Program (QMP) monitors and evaluates quality across the entire range of services provided by the company. Along with the trending of quality issues at the Engagement Center level, the National QMP is intended to ensure that structure and processes are in place to lead to desired outcomes for *members, clients, providers/participating practitioners*, and internal clients. The scope of the National QMP includes:

- (a) Clinical services and *Utilization Management Programs*;
- (b) Supporting improvement of continuity and coordination of care
- (c) Case Management/Intensive Case Management
- (d) Quality Improvement Activities (QIAs)/Projects (QIPs);
- (c) Outcome Measurement and data analysis;
- (d) Network Management/Provider Relations Activities;
- (e) Satisfaction Survey;
- (f) Clinical Treatment Record Evaluation;
- (g) Service Availability and Access to Care;
- (h) Practitioner and Provider Quality Performance;
- (i) Annually evaluating member *Complaints and Grievances (Appeals) using valid methodology*;
- (j) *Member Rights and Responsibilities*;
- (k) Patient Safety Activities;
- (l) Clinical and *Administrative Denials and Appeals*;
- (m) Performance Indicator development and monitoring activities; and
- (n) Health Literacy and Cultural Competency assurance, and
- (o) Promotion of e-technologies to improve member access and understanding of health benefits.

Several of the above activities and processes are described in greater detail in other sections of this *Resource Guide*.

Role of Participating Providers

Participating practitioners/providers are informed about the QMP via the ValueOptions Provider Manual, *provider newsletters, ValueOptions.com website*, direct mailings, email provider alerts, seminars and training programs. Many of these media venues provide network *practitioners/providers* with the opportunity to be involved and provide input into the QM and UM Programs. Additional opportunities to be involved include representation on the Provider Stakeholder, National Credentialing, and Provider Appeals Sub-Committees as well as on various committees and sub-committees and/or workgroups at the Engagement Center level (i.e., Local Credentialing Committee and *Clinical Advisory Committees*). Involvement includes but is not limited to:

- Providing input into the ValueOptions Clinical Criteria;
- Providing peer review and feedback on proposed practice guidelines, clinical quality monitors and indicators, new technology and any critical issues regarding *policies and procedures* of ValueOptions;
- Reviewing Quality Improvement (QI) activities and making recommendations to improve quality of clinical care and services;
- Reviewing, evaluating and making recommendations for the credentialing and re-credentialing of *participating practitioners and organizational providers*; and
- Reviewing, evaluating and making recommendations regarding sanctions that result from *participating practitioner and organizational provider* performance issues.

As part of the QMP, ValueOptions incorporates principles designed to encourage the provision of care and treatment in a culturally competent and sensitive manner. These principles include: (a) emphasis on the importance of culture

and diversity; (b) assessment of cross-cultural relations; (c) expansion of cultural knowledge; and (d) adaptation of services to meet the specific cultural and linguistic needs of *members*. *Participating providers* are reminded to take the cultural background and needs of *members* into account when developing treatment plans.

Quality Performance Indicator Development and Monitoring Activities

A major component of the quality management process is the identification and monitoring of meaningful performance indicators. National level key performance indicators (KPI) are established, collected and reported for a small but critical number of performance measures across Engagement Centers all functional areas of the company. These key performance indicators are selected by functional area leads along with associated goals or benchmarks and are approved by senior management. Company-wide key performance measures are reported to the Executive Quality Council/governing body at least annually.

All functional areas are responsible for prioritizing their resources to meet or exceed performance goals or benchmarks established for each indicator. When performance is identified below established goals and or trends are identified, a corrective action plan is submitted to improve performance.

Engagement Centers are expected to identify, track and trend local key performance indicators relevant to the populations they serve. Client performance reporting requirements may be client prescribed. In any case, behavioral health care access and service performance is monitored regularly including but not limited to:

- Access and availability to behavioral health services,
- Telephone service factors, Utilization decision timeliness and adherence to medical necessity and regulatory requirements,
- Member and provider *complaints* and *grievances*,
- Member and provider satisfaction with program services, and
- Nationally recognized or locally prescribed care outcome indicators such as HEDIS® whenever possible.

Potential quality of care and/or service indicators monitored by ValueOptions include, but are not limited to:

- Provider Inappropriate/Unprofessional Behavior
 - Sexual relationship with *member*
 - Seductive behavior, inappropriate physical contact
 - Aggressive behavior
 - Threats of aggressive behavior
 - Displays signs of substance abuse
 - Displays signs of mental health problems
 - Displays signs of organicity
 - Inappropriate pharmacy/drug prescribing
- Clinical Practice-Related Issues
 - Treatment Setting not Safe
 - Adequacy of assessment
 - Timeliness of assessment
 - Accuracy of *diagnosis*
 - Delay in treatment
 - Appropriateness of treatment
 - Effectiveness of treatment
 - Adequacy of referral
 - Failure to appropriately refer
 - Timeliness of referral
 - Failure to coordinate care
 - Abandoned *member*
 - Premature discharge
 - Inadequate discharge planning
 - Prescribed wrong, too much, too many, too little medication
 - Medication Error
 - Failure to follow Practice Guidelines
 - Failure to involve family in treatment
 - Over or under utilization of services

- Access to Care-Related Issues
 - Failure to provide appropriate appointment access
 - Lack of timely response to telephone calls
 - Prolonged in-office wait time
 - Session too short
 - Falling asleep

- Attitude and Service-Related Issues
 - Failure to maintain confidentiality
 - Poor communication skills
 - Lack of caring/concern
 - Poor or lack of documentation
 - *Fraud* and Abuse
 - Failure to release medical records
 - Failure to allow site visit

- Other Monitored Events
 - Self-inflicted harm requiring *urgent* or *emergent* medical treatment;
 - Attempted suicide by a *member* currently under treatment that results in inpatient admission;
 - Unanticipated death (occurring in any setting) not related to the natural course of the *member's* medical illness or underlying condition (e.g. suicide, homicide, death by medical cause);
 - Violent/Assaultive behavior with physical harm to self or others (e.g. attempted murder, actual assault);
 - Serious Adverse reaction (e.g. requiring medical treatment) to treatment (e.g. neuroleptic malignant syndrome, tardive dyskinesia, other serious reaction);
 - Sexual behavior with other patients or staff, whether consensual or not, while in a treatment program;
 - Elopements from a hospital or RTC where the *member* is considered a danger to self or others;
 - Injuries either in a facility or a *provider* office that require *urgent* or *emergent* medical treatment;
 - Fire setting/property damage while in a treatment setting;
 - Medication errors or major adverse drug reaction resulting in the need for *urgent* or *emergent* medical intervention;
 - Withdrawal seizures while hospitalized for detoxification;
 - More than three hospitalizations within (1) calendar year;
 - Readmission within thirty (30) days;
 - Accidental injuries while in a treatment setting;
 - Breach of confidentiality;
 - Inappropriate or unsafe use of seclusion or restraints;
 - Allegations of abuse/neglect by a *provider*/facility while in treatment;
 - Any request for a change of *provider*/facility while in active treatment;
 - 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)

Service Availability and Access to Care

ValueOptions uses a variety of mechanisms to measure *member's* access to care with participating *practitioners*. Unless other appointment availability standards are required by a specific client or government sponsored health benefit program, service availability is assessed based on the following standards for participating practitioners:

- An individual with life-threatening emergency needs is seen immediately
- An individual with non-life-threatening emergency needs is seen within 6 hours
- An individual with urgent needs is seen within 48 hours
- Routine office visits are available within 10 business days

The following methods may be used to monitor *participating provider* behavioral health service availability and *member* access to care:

- Analysis of *member complaints* and *grievances* related to availability and access to care.
- *Member* satisfaction surveys specific to their experience in accessing care and routine appointment availability.
- Open shopper staff surveys for appointment availability; An approach to measuring timeliness of appointment access in which a surveyor contacts *participating provider's* offices to inquire about appointment availability and identifies from the outset of the call that he or she is calling on behalf of ValueOptions.
- Referral line calls are monitored for timeliness of referral appointments given to *members*.
- Analysis and trending of information on appointment availability obtained during site visits.
- Analysis of call statistics (i.e. average speed of answer, abandonment rate over 5 seconds)
- Annual Geo-Access and network density analysis (see Network policies and procedures).

In addition to these monitoring activities, *participating providers* are required by contract to report to network management when they are at capacity. This assists customer service in selecting appropriate, available *participating* practitioners for *member* referral.

Continuity and Coordination of Care

ValueOptions monitors continuity and *coordination of care* throughout its continuum of behavioral health services. Monitoring may include reviews and audits of treatment records, coordination of discharge planning between inpatient and outpatient *providers/participating providers*, and monitoring *provider/participating provider* performance on pre-determined *coordination of care* indicators. Processes are established seeking to avoid disruption of care for the *member* when there is a change in their treating *provider/participating provider*. Such changes may include, but are not limited to:

- A *member* requires a change in *level of care*, necessitating a new *participating provider*
- There are multiple *providers/participating providers* involved in treatment simultaneously (psychiatrist for medication management, therapist for on-going treatment)
- A change in health plans or benefit plans
- Termination of a *participating provider*
- A *member* is being treated for several (co-morbid) conditions simultaneously with multiple *providers/participating providers* (both behavioral health specialists and primary care or medical specialists)

Subject to any *member* consent or *authorization* required by applicable state and/or federal laws and/or regulations, *participating providers* should coordinate care as appropriate, sharing information with other treating *providers/participating providers*, within the context of providing quality care and within the guidelines of protecting a *member's* privacy and confidentiality.

Treatment Record Standards & Guidelines

Member treatment records should be maintained in compliance with all applicable medical standards, laws, rules and regulations, as well as ValueOptions' *policies and procedures* and in a manner that is current, comprehensive, detailed, organized and legible to promote effective patient care and quality review. ValueOptions *policies and procedures* incorporate standards of accrediting organizations to which ValueOptions is or may be subject (e.g., the *National Committee for Quality Assurance (NCQA)* and *URAC*, as well as the requirements of applicable state and federal laws, rules and regulations.

References to 'treatment records' mean the method of documentation, whether written or electronic, of care and treatment of the *member*, including without limitation medical records, charts, medication records, physician/practitioner notes, test and procedure reports and results, the treatment plan, and any other documentation of care and/or treatment of the *member*.

Progress notes should include what psychotherapy techniques were used, and how they benefited the *member* in reaching his/her treatment goals. Progress notes do not have to include intimate details of the *member's* problems but should contain sufficient documentation of the services, care and treatment to support *medical necessity* of same. Intimate details documenting or analyzing the content of conversations during a private counseling session or a group, joint or family counseling session should be maintained within the psychotherapy notes and kept separate from the *member's* treatment record made available for review and audit.

Member treatment record reviews and audits are based on the record keeping standards set out below:

1. Each page in the treatment record contains the patient's name or identification number.
2. Each record includes the patient's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant.
3. All entries in the treatment record are dated and include the responsible clinician's name, professional degree, and relevant identification number, if applicable. The length of the visit/session is recorded.
4. The record is legible to someone other than the writer.
5. Medication allergies, adverse reactions and relevant medical conditions are clearly documented and dated. If the patient has no known allergies, history of adverse reactions or relevant medical conditions, this is prominently noted.
6. Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status and the results of a mental status exam, are documented.
7. Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented and revised in compliance with written protocols.
8. Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.
9. A medical and psychiatric history is documented, including previous treatment dates, practitioner identification, therapeutic interventions and responses, sources of clinical data and relevant family information. For children and adolescents, past medical and psychiatric history includes prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic). For patients 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed and over-the-counter drugs.
10. A DSM/ICD (most current version)-*diagnosis* is documented, consistent with the presenting problems, history, mental status examination and /or other assessment data.
11. Treatment plans are consistent with diagnoses, have both objective, measurable goals and estimated timeframes for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable.
12. Continuity and *coordination of care* activities between the primary clinician, consultants, ancillary providers and health care institutions are documented as appropriate.

13. Informed consent for medication and the patient's understanding of the treatment plan are documented.
14. Progress notes describe the patient's strengths and limitations in achieving treatment plan goals and objectives and reflect treatment interventions that are consistent with those goals and objectives. Documented interventions include continuity and *coordination of care* activities, as appropriate. Dates of follow-up appointments or, as applicable, discharge plans are noted.

In addition to other requests for *Member* treatment records included in this *Resource Guide* and/or the *provider agreement*, *Member* treatment records are subject to focused and random audits by ValueOptions Quality Management Department or its designee, as well to audits by state, local and federal regulatory agencies and *accreditation* entities to which ValueOptions is or may be subject.

Treatment Record Reviews

Participating provider participation in random treatment record reviews and audits is an integral part of ValueOptions QMP. *Participating providers* are required to cooperate with treatment record reviews and audits conducted by ValueOptions and associated requests for copies of *member* records. For the purpose of conducting retrospective case reviews, treatment records for ValueOptions *members* should be maintained for the time period(s) required by applicable state and/or federal laws and/or regulations, and as detailed in the *provider agreement*.

ValueOptions may conduct treatment record reviews: (a) on a random basis as part of *continuous quality improvement* and/or monitoring activities; (b) as part of routine quality and/or billing audits; (c) as may be required by clients of ValueOptions; (d) in the course of performance under a given client contract; (e) as may be required by a given government or regulatory agency; (f) as part of periodic reviews conducted pursuant to *accreditation* requirements to which ValueOptions is or may be subject; (g) in response to an identified or alleged specific quality of care, professional competency or professional conduct issue or concern; (h) as may be required by state and/or federal laws, rules and/or regulations; (i) in the course of claims reviews and/or audits; and/or (j) as may be necessary to verify compliance with the *provider agreement*.

Treatment record reviews and/or audits may be conducted through on-site reviews in the *participating provider's* office or facility location, and/or through review of copies of documents and records supplied by the *participating provider*. Unless otherwise specifically provided for in the *provider agreement* and/or other sections of this *Resource Guide* with respect to a particular type of record review or audit, *participating providers* must supply copies of requested records to ValueOptions within five (5) business days of the request.

ValueOptions will use and maintain treatment records supplied by *participating providers* for review and/or audit in a confidential manner and in accordance with applicable laws and regulations regarding the privacy or confidentiality of protected health information and/or patient identifying information. Never send original records as they will not be returned at the completion of the review or audit.

Records are reviewed by licensed clinicians. Treatment records reviews and/or audits conducted as part of Quality Management activities include application of an objective instrument. The instrument is continuously under study and revision; ValueOptions reserves the right to alter/update, discontinue and/or replace such instrument in its discretion and without notice.

Following completion of treatment record reviews and/or audits, ValueOptions will give the *participating provider* a written report that details the findings. If necessary, the findings report will include a corrective action plan with specific recommendations that will enable the *participating provider* to more fully comply with ValueOptions standards for treatment records.

Improving Patient Safety

ValueOptions has a defined procedure for the identification, reporting, investigation, resolution and monitoring of quality of care and service issues and trends. Quality of care and service issues and trends are those that decrease the likelihood of desired health outcomes and that are inconsistent with current professional knowledge. These types of issues may be identified from a variety of sources, including without limitation *member* and *provider/participating provider complaints*, internal reviews, clients, government agencies and others. These concerns are resolved and monitored at both the Engagement Center and network-wide level. Engagement Centers have a designated committee, in which the Engagement Medical Director participates, that oversees the investigation and resolution of these issues through to completion.

Professional Review/Fair Hearing Process

Individual *Providers/participating providers* may request a second level of *appeal/a fair hearing* when the PAC denies credentialing, re-credentialing, issues a sanction or recommends termination of participation status from the ValueOptions provider network based on quality of care issues and/or issues related to professional competence or professional conduct. Information about the *fair hearing* process is located in the *appeals* section of this *Resource Guide*.

Adverse Incidents

Participating providers are required to report to ValueOptions within twenty-four (24) hours all “*adverse incidents*” involving *members*. *Adverse incidents* are defined as “occurrences that represent actual or potential serious harm to the well being of *member’s* or to others by a *member* who is treatment or has been recently discharged (i.e. within the past twelve (6) months) from behavioral health treatment/EAP services.” *Participating providers* should report all *adverse incidents* to the *Clinical Care Manager* with whom the *participating provider* conducts 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). An example of exclusion would be a chronic medical cause that is considered terminal in nature without other attributing factors of concern.
- 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 *member* 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 *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).

Participating 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 may undertake an investigation designed to provide for *member* safety. As a result, *participating providers* may be asked to furnish records, and/or engage in corrective action to address quality of care concerns and any identified or suspected deviations from a reasonable standard of care. *Participating providers* may also be subject to disciplinary action through the National 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.

Quality Improvement Activities/Projects

One of the primary goals of ValueOptions' National Quality Management Program (QMP) is to continuously improve care and services. Through data collection, measurement and analysis, aspects of care and service that demonstrate opportunities for improvement are identified and prioritized for quality improvement activities. Data collected for quality improvement projects and activities are frequently related to key industry measures of quality that tend to focus on high-volume diagnoses or services and at high-risk or special populations. Data collected are valid, reliable and comparable over time. ValueOptions takes the following steps to ensure a systematic approach to the development and implementation of quality improvement activities:

- Monitoring of clinical quality indicators;
- Review and analysis of the data from indicators;
- Identification of opportunities for improvement;
- Prioritization, based on risk assessment, ability to impact performance, and resource availability, of opportunities to improve processes or outcomes of behavioral healthcare delivery;
- Identification of the affected population within the total membership;
- Identification of the measures to be used to assess performance;
- Establishment of performance goals or desired level of improvement over current performance;
- Collection of valid data for each measure and calculation of the baseline level of performance;
- Thoughtful identification of interventions that are powerful enough to impact performance; and
- Analysis of results to determine where performance is acceptable and, if not, the identification of current barriers to improving performance.

Experience/Satisfaction Surveys

ValueOptions, either directly or through authorized designees, conducts some form of experience and/or satisfaction survey to identify areas for improvement as a key component of the QMP. Satisfaction survey participation may include *members*, *participating providers* and/or clients.

Member experience and/or satisfaction surveys measure opinions about clinical care, *participating providers*, and ValueOptions' administrative services and processes. *Members* are asked to complete satisfaction surveys at various points in the continuum of care and/or as part of ongoing quality improvement activities. The results of these *member* surveys are summarized on a semi-annual basis. Where appropriate, corrective actions are implemented in the ValueOptions' functional department or as applicable in the Engagement Center.

Annual *Participating provider* satisfaction surveys measure opinions regarding clinical and administrative practices. The results of *participating provider* surveys are aggregated and used to identify potential improvement opportunities within ValueOptions and possible education or training needs for *participating providers*. Where appropriate, corrective actions are implemented in the ValueOptions' functional department or as applicable in the Engagement Center.

Site Visits for Quality Reviews

ValueOptions, or its designee, conducts site visits at *participating provider* facilities and/or offices. A site visit may be conducted as part of monitoring an investigation stemming from a *member complaint* or other quality issue. The current ValueOptions QM site visit tool and associated forms are available for review on our *ValueOptions.com website*. ValueOptions reserves the right to modify or replace the site visit tool and associated forms without notice.

ValueOptions will contact the *participating provider* to arrange a mutually convenient time for the site visit. The QM site visit process is intended to be consultative and educational. Following the site visit, the *participating provider* will receive a written report detailing the findings of the site visit. If necessary, the report will include an action plan that will

provide guidance in areas that the *participating provider* needs to strengthen in order to be in compliance with ValueOptions' standards.

Complaints and Grievances

One method of identifying opportunities for improvement in processes at ValueOptions is to collect and analyze the content of *member, provider/participating provider, and client complaints*. The ValueOptions *complaints and grievance* process has been developed to provide a structure for timely responses and for local ValueOptions Engagement Centers to track and trend *complaint and grievance* data by providing categories into which *complaints and grievances* may be sorted. Engagement Center *complaints and grievance* data is compiled and reported to the Quality Management Committee (QMC) at least quarterly.

[Back to Table of Contents](#)

Appendices

- I. [Clinical Criteria](#)
 - II. [Treatment Guidelines](#)
 - III. [Clinical Recommendations and Best Practices \(links to newly created Horizon-specific document\)](#)
 - IV. [Member Rights \(English\) \(PDF\)](#)
 - V. [Member Rights \(Spanish\) \(PDF\)](#)
 - VI. [Administrative Forms](#)
 - VII. [Clinical Forms](#)
 - VIII. [Medicare Advantage Specific Provisions](#)

[Back to Table of Contents](#)