VALUEOPTIONS
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Kaiser Permanente
Frequently Asked Questions

Q: What is the effective date that this transition will occur?
A. The *ValueOptions/Kaiser* Permanente Service Center becomes operational on May 1, 2006. Kaiser Permanente has contracted with *ValueOptions* and its associated treatment providers to develop a comprehensive provider network
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Q: What is the transition benefit plan for members whose providers are not credentialed for ValueOptions' HMO network and in the credentialing process on 5/1/06?
A. For PRO Behavioral Health, PRO providers who are not ValueOptions contracted providers on May 1, 2006 and choose not to join ValueOptions ' network, the following transition benefit and timeframe will apply.

- Either the Member or the Provider must contact ValueOptions to preauthorize transition benefit sessions of either initial 8 therapy and/or 6 medication management sessions.
- The transition period extends from 5/1/06 to 7/31/06 and will not extend beyond these 90 days. Transitions benefits can be extended past 90 days based on clinical review. A provider can provide clinical justification for medical necessity which will be reviewed by ValueOptions.

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These transition units are intended to provide the opportunity to complete treatment or to arrange transfer to an in network provider when required by the benefit plan. **Upon completion of these transition units, any limitations in the member's benefit plan will take effect.** These sessions will count towards the member's benefit limit. We recommend that you contact ValueOptions to verify the provisions and limitations of the member's benefit

Authorization for Care Prior to and After May 1, 2006:

Inpatient Level of Care

- If you are treating a Kaiser Permanente member at an **Inpatient level of care** that requires telephone authorization and the member was admitted prior to May 1, 2006 and care is expected to continue beyond May 1, 2006 then you will continue to review with PRO until discharge and/or a lower level of care is needed
  - At the point any member needs a step-down level of care; you must contact ValueOptions to preauthorize this care on or after May 1, 2006.
- For inpatient care needed on or after May 1st, providers will need to contact ValueOptions at **888-681-7878** to authorize care
- NOTE: Claims for dates of service authorized by PRO will need to be sent to PRO. Claims for dates of service authorized by ValueOptions will need to be sent to the ValueOptions claims address noted below.

Alternative Level of Care (Residential, Partial, Intensive Outpatient, etc.)

- For members in alternative levels of care which is initiated and authorized by PRO prior to and needs to continue after May 1st, you must contact ValueOptions at **888-681-7878** on May 1st with clinical information for concurrent authorization.

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- For alternative level of care needed on or after May 1st, providers will need to contact ValueOptions at **888-681-7878** to authorize care
- NOTE: Claims will need to be split depending on the dates of service
  - For dates of service on or before April 30th will need to be sent to PRO.
  - If the member continues in the same alternative level of care on and after May 1st, even if the dates of service were authorize by the IPRO, the claims need to be sent to the ValueOptions' claims address noted below.

Continued Stay review:

- Inpatient and higher levels of care (PHP, IOP) require telephonic review with a ValueOptions Clinical Care Manager. All requests for authorization of continued stays should be made in advance of the expiration of the preauthorization so that no lapse in services occurs. . **Please note that it is the provider's responsibility to call ValueOptions to request continued stays or concurrent reviews**. Providers should make these telephone calls according to the instructions contained in our **Provider Manual which can be accessed at www.valueoptions.com**.
- Failure to initiate concurrent review telephone calls by providers may result in non-payment of claims.

Outpatient Levels of Care

The member's benefit plan will define whether or not the member can utilize out-of-network (OON) providers. Should you have any questions about OON benefits please contact Customer Service at 888-681-7878 on May 1, 2006.

- Members are allowed two pass through visits for evaluation. An ORF (outpatient request form) is required at this time. Please fax the Med Management form to 518-266-3215.
- Forms are available at www.valueoptions.com.
- Failure to submit the ORF and/or medication ***management*** forms may result in ***non-payment*** of claims.

Providers should **submit claims** in accordance with ValueOptions' claims procedures. Details regarding ValueOptions claims procedures can be accessed through the ValueOptions website (**www.valueoptions.com**).

Provider Network – Contracting and Credentialing

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

A. Effective May 1, 2006, your ValueOptions contract Kaiser Permanente. Kaiser Permanente will require a HMO addendum. You will receive a letter from Kaiser Permanente and ValueOptions notifying you of this change and necessary actions.

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Q: I am not a provider in the ValueOptions network. What do I do to join the network?
A: If you are not a contracted provider with ValueOptions please note the following:

ValueOptions and Kaiser Permanente are currently reviewing our mutual network coverage areas, clinical specialty needs, and member access. It is our intent to minimize care disruption of any members in active treatment and to that end, ValueOptions will send copies of an agreement and addendum outlining the business rules as well as a ValueOptions Commercial Fee Schedule attachment Kaiser Permanente., ValueOptions will notify those providers needed for the network via mail to determine your level of interest in joining the ValueOptions network.

What Do I Do Next?

In the several weeks, ValueOptions will be providing additional information about this program including transition requirements, clinical authorization requirements, claims policies, and mailing addresses, at www.valueoptions.com. In addition, ValueOptions will continue to update this Frequently Asked Questions' (FAQ) document when more information is available. If you have questions please call the ValueOptions National Provider Line at 1-800-397-1630

Q: What fee schedule will be used if I am intending on becoming a ValueOptions provider?
A: Effective 5/1/06, the ValueOptions Commercial Fee Schedule details the payment (by CPT Code and licensure) that you will receive for providing services to the Commercial/ Non-HMO Network and HMO membership.

Q: My current Outpatient fee schedule is more favorable than ValueOptions' fee schedule. With whom do I discuss my ValueOptions fee schedule? (For individual practitioner's or outpatient clinics/groups only)
A: ValueOptions' fee schedules for outpatient services are reviewed routinely and at present are determined to be competitive with other companies with similar HMO business across the United States. In general, our fee schedules for outpatient services are non-negotiable.

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

Deanna Stephenson, Director of Provider Relations
ValueOptions
433 River Street
Suite 5000
Troy, NY 12180

You must include the following in the letter:
- Last Name, First Name
- Tax Identification or Social Security number
- Primary Mailing Address, City, State, Zip
- Practice address(s) with City, State, Zip

- Primary contact number with area code
- Name of Primary contact if different than your own
- List of codes and counter proposed rates

Q: My current Inpatient/Alternative Levels of Care fee schedule is more favorable than ValueOptions' fee schedule. With whom do I discuss my fee ValueOptions fee schedule? (for Inpatient facilities only).

A. ValueOptions' reimbursement schedules for inpatient services have been determined to be competitive with other companies with similar HMO business across the United States. In general, our inpatient reimbursement schedules are non-negotiable. If you believe that your fee schedule needs to be reviewed, please submit a Letter of Request regarding Rate Schedule to:

Nicky Hazlewood, Corporate Director, Provider Contracting
ValueOptions
12369C Sunrise Valley Drive
Reston, Virginia 20191

You must include the following in the letter:

- Facility Name
- Tax Identification number
- Primary Mailing Address, City, State, Zip
- Practice address(es) with City, State, Zip
- Primary contact number with area code
- Name of Primary contact if different than your own
- Levels of Care by Service Location
  (E.g. Inpatient and PHP for MH at 123 Brown Street)
- List of codes and counter proposed rates.

Q: Do I have to be credentialed by ValueOptions?

A: Yes, all providers need to be credentialed to be included within the ValueOptions network.

Q: I just completed my credentialing/recredentialing with PRO Behavioral Health; can you accept the Kaiser Permanente materials instead of me completing the ValueOptions application?

A: No, ValueOptions requires specific information and all providers must be credentialed by ValueOptions in order to be considered as an in-network provider.

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Online Services

Q: What online services does ValueOptions offer?
A: ValueOptions has enhanced our on-line services to provide added convenience for our members and providers. The following services available are:

ProviderConnect is an enhanced version of our online transaction services. It is a self-service tool available 24/7 that gives you access to the following features: single and multiple electronic claims submission, claims status review (for both paper and online submitted claims), eligibility status, your provider practice profile, and correspondence (which includes authorizations). Find more information about ProviderConnect on www.valueoptions.com

Claims

Claims for all dates of service prior to April 30th, 2006 should be submitted to the claim address on the member's Kaiser Permanente ID card. Any questions regarding claims for these dates of service should be directed to Kaiser Permanente customer service number listed on the member's ID card.

Claims for services rendered by participating ValueOptions providers with dates of service on or after May 1st, should be submitted to ValueOptions at:

PO Box 1770
Latham, NY 12110

Any questions regarding claims on or after May 1, 2006 should be directed to ValueOptions at 1-888-681-7878

Kaiser Permanente will be responsible for reimbursement of pre-certified inpatient admissions commencing prior to May 1, 2006 and any other services rendered **PRIOR** to May 1, 2006, therefore, please submit claims with dates of service prior to May 1, 2006 to the Kaiser Permanente address indicated on the member's ID card.)

For outpatient and alternate level of care claims that span May 1st: please split the claims according to dates of service and submit to the authorizing agent, i.e., PRO or ValueOptions.

- Inpatient care that began before May 1st but will continue after must be authorized by PRO.
- Claims for inpatient levels of care need to be sent to the company who authorized the care

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1. ValueOptions will be responsible for reimbursement of pre-certified services rendered **ON or AFTER** May 1, 2006, by ValueOptions participating providers. Please submit these claims to:

   ValueOptions
   PO Box 1770
   Latham, NY 12110

   If care takes place both before and after the May 1, 2006 implementation date, please split the claim accordingly.

2. Claims submitted by non-participating providers beyond the transition benefit date that are not authorized will be denied.

Q. What paper forms can be used for claims submission?
A. Providers are required to bill on standard CMS 1500 and UB92 forms. Red ink forms should be used as these can be scanned, which expedites the claim entry into the claims system. The UB92 Form can only be used for inpatient and alternative levels of care for mental health and substance abuse, not outpatient professional mental health services. The CMS 1500 form should be used for outpatient professional services.

Q. Can I submit my claims electronically to ValueOptions?
A. Yes. CMS 1500 and UB92 electronic submissions are accepted according to guidelines contained in the ValueOptions EDI materials found on www.valueoptions.com. If you are interested in electronic claim submission, please contact our ValueOptions Electronic Claims Specialist at 888-247-9311. We strongly encourage providers to submit claims electronically for the efficiencies gained by both providers and in claims processing.

Q. Does the ValueOptions electronic claims format work with MedLink and other claims clearing houses?
A. Please contact our ValueOptions Electronic Claims Specialist at 888-777-4742. Please note: ValueOptions does not reimburse for provider expenses associated with electronic claims submission.

Q. When ValueOptions authorizes care is the authorization an automatic guarantee of payment for services rendered?
A. No, authorization of services is not a guarantee of payment. Payment depends on a number of factors including member eligibility, provider contract status, and benefit limits at the time care is rendered.

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Q. As an individual practitioner, billing outpatient services, do I need to include the provider number on my claims?

A: Outpatient professional services must be billed on a CMS-1500 form. The following fields are required

CMS-1500 required fields:

- Insured's ID number
- Patient's name
- Patient's birth date and gender
- Insured's name
- Patient's address, city, state, zip code and telephone number
- Patient's relationship to the insured
- Insured's address, city, state, zip code and telephone number
- Patient status – married / single
- Is the patient's condition related to: Employment? Auto accident? Other accident?
- Is there another health benefit plan?
- Diagnosis or nature of illness or injury
- Dates of service
- Place of service
- Procedures, services or supplies CPT/HCPCS
- Procedures, services or supplies modifier
- Charges
- Days or units
- Federal Tax ID number and type
- Total charge
- Signature of physician or supplier including degrees or credentials
- Name and address of facility where services were rendered
- Physician's/supplier's billing: name, address, zip code and phone number

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

Q. For claims previously rejected that need to be resubmitted, what do I need to do?

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

ValueOptions
PO Box 1770
Latham, NY 12110

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

Q. As a facility billing for outpatient services, what information is required to be included on my claims?

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

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Q. As a Facility billing for services other than outpatient, how do I bill?
A: Inpatient services and Alternate Levels of Care (PHP, IOP, etc.) must be billed on a UB-92 form. The following fields are required:

UB-92 required fields:

- Provider name, address and telephone number
- Type of bill
- Federal tax number
- Statement covers period "From" and "Through"
- Patient's name (last, first name, middle initial)
- Patient's address
- Birth date
- Sex
- Marital status
- Admission date
- Patient status
- Responsible party name and address
- Revenue code
- Service date
- Service units
- Total charges
- Payer
- Release of information certification indicator
- Assignment of Benefits
- Insured's name (last, first name, middle initial)
- Patient's relationship to insured
- Certificate No. – Social Security Number – Health Insurance Claim Identification Number
- Group name
- Principal diagnosis code
- Admitting diagnosis code
- Attending physician identification number
- Provider representative
- Date

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

Q. Who pays when the member is admitted to a medical unit for alcohol withdrawal treatment?
A. When the seriousness of the medical condition that admission to a medical unit is required and Kaiser Permanente authorizes it, the expense shall be a medical expense and processed by Kaiser Permanente.

Q. Who is responsible for members admitted to an inpatient medical unit with behavioral health issues that need to be treated?
A. Members admitted to a medical floor are the responsibility of the medical plan. Authorization is required by the medical plan and claims are paid by the medical plan. If the member is transferred to a psychiatric or substance abuse unit (except for medical detoxification), ValueOptions will need to review, authorize the care, and pay the claims.

Q. Who is responsible for members admitted to a behavioral health unit?
A. Members admitted to a behavioral health unit require an authorization by ValueOptions. Please contact ValueOptions and request an authorization.

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Q. On or after 5/1/06, where do I go to have a claim question/issue resolved?
A. Please visit us on-line at www.valueoptions.com to check and review a claim status or call **1-888-681-7878**

Q: I'm used to billing a 90809 and 90802 for services. I do not see that code on your current fee schedule. Are these services reimbursable?
A: ValueOptions does reimburse providers for these services at the same rate as a 90807 and 90801 respectively.

Clinical, Authorization and Quality Services

Q. What are the hours of the ValueOptions Clinical Department?
A. Licensed clinicians are available 24-hours a day, 7 days a week, and 365 days a year. It is imperative that, in the event of emergent care, the provider contact ValueOptions as soon as possible, but no later than 24-hours after the emergent contact/session/admission.

Q. As an inpatient Provider, how soon after an admission do I have to authorize care?
A. Pre-certification is required for all services; however, after completing the evaluation, the provider should contact ValueOptions. Please call ValueOptions by dialing the number on the back of the member's insurance card to review the emergency, what services are offered, and the clinical information. This includes nights, weekends, and holidays, as our phone lines are open 24 hours a day 7 days a week, 365 days per year.

Q. As a provider, how soon will I receive a claims payment?
A. If provider submits a clean claim electronically within timely filing limits, compensation to the provider shall be at the rates specified in the reimbursement schedule and paid to the provider within 30 days.