

Other Frequently Asked Questions: Webinars and Forums

Q: What is the turnaround time for payment for electronic claims vs. paper claims?

A: Generally the difference in turnaround time can be up to 7-15 business days between EDI and paper. The EDI claims enter the claims processing system immediately and will either auto adjudicate or pend for examiner review. Paper claims there is the delay in mail time. Upon receipt, the mail then has to be opened, sorted and batched to be scanned into RRI. The claims then go through a manual review to be keyed and verified before being entered into the claims system. At this point the claim will either auto adjudicate or pend for examiner intervention. The claims inventory is worked by age (receipt date). Therefore, the faster the claims are entered into the system, the faster they are processed.

Q: How can I set up electronic claims submission with ValueOptions®?

A: This is the information on electronic billing with ValueOptions® – this information is all available on our website and a link to detailed information is provided as well.

http://www.valueoptions.com/providers/Compliance/837_Companion_Guide.pdf

This is the direct link for our 837 companion guide. Providers can find it under the provider tab on Valueoptions.com – on the left hand side there is a link that says Compliance. If you click on that there are various guides that you can review (auth request, direct claim submission, as well as the companion guide). If the provider is dealing with a clearinghouse, not much should change from the providers' perspective. ValueOptions® can work directly with the clearinghouse if the provider contacts the EDI HelpDesk at (888) 247-9311 and press option 3, Monday through Friday, 8 a.m. – 6 p.m. ET and provides the staff there with the information or they can have the clearing house contact us directly. If you want us to do outreach to specific clearinghouses, either the providers can call here with the information or e-mail it to e-supportservices@valueoptions.com.

Q: If you are a provider for ValueOptions® but NOT MVP would you be credentialed to see MVP patients as an in network provider?

A: ValueOptions® will be sending a mailing to the ValueOptions® providers in the next 14 days to add MVP Health Care to your ValueOptions® agreement

Q: Will be submitting electronic claims be mandatory?

A: Submitting claims electronically is not mandatory however it is recommended.

Q: What is the Fax number for sending out ORF's?

A: ValueOptions® will be adopting the MVP Health Care fax numbers. Providers will be able to continue to just fax to these numbers.

Q: How can psychiatric evaluations that are longer than 1 hour be billed?

A: The "Community Standard" for initial child psychiatric evaluations is lengthier and more complex than the same service provided for adults. In adult psychiatry, medication evaluation is typically included in the 90801 coding, whereas in child psychiatry it is not unusual to code these services separately to reflect the lengthier and more complicated evaluation process. This is a practice Washington County does allow in the case of initial child psychiatric assessments only. In these cases, 90801 and 90862 may be billed by the same medical provider on the same date of service. The CPT code manual does not specifically prohibit this practice because the service code definitions do not overlap. The definition for 90801 is clearly an assessment and diagnostic

interview and does not specifically include pharmacologic therapy. 90862 has in its definition "1) prescribing medication, 2) monitoring the effect of medication and its side effects, and adjusting the dosage. Any psychotherapy provided is minimal and is usually supportive in nature."

Q: Can I receive authorization and submit claims for more than one 90801 session for a child or adolescent member?

A: Providers that strongly believe that they clinically require more than one 90801 evaluation should call Customer Service. The provider will be asked to give a time when he/she is available to receive a call back from a Clinical Care Manager as ValueOptions will need to evaluate this request for the additional 90801s. This is not an automatic authorization, and the request does not fall within one of the areas as identified below, the request will be sent to a ValueOptions peer advisor for additional medical necessity review. Criteria are:

- 1) Child or Adolescent with as complex clinical presentation (i.e. not an ADHD evaluation)
 - a. Psychosis
 - b. Suicidality
 - c. OCD
 - d. Family involved in treatment
 - e. Co-morbid Medical Issues

Q: What is the claim mailing address?

ValueOptions®
PO Box 1408
Latham, NY 12110

Q: Can authorization be back dated? If so, how far back?

A: Exceptions will be allowed during the transition period.

Q: Can the 8 pass through sessions be carried over to the following year?

A. Members pass through sessions renew every year. Benefits can renew on either a benefit or calendar year.

Q: When do authorizations expire?

A. Authorization will have a begin date and end date with a total number of sessions. It is recommended that providers submit a new treatment request at least two weeks prior to the last authorized date.

Q: The 1st 8 visits allowed with no auth, is that per provider or for all providers?

A: It is per member

Q: When do benefits reset, calendar year or contract year?

A: This varies by plan

Q: If there is an auth on file for a PHD who is providing therapy and we have another PHD who will be doing Neuro Testing (96118) for the same client & will require an evaluation (90801) first. Do we need to obtain an additional auth for the testing provider?

A: Yes, all testing needs to be preauthorized. Neuropsych testing is done under the MVP benefit.

Q: Will authorization be required for 90862s?

A: Authorization will not be required for the first 12 visits. Any visits beyond that will require authorization.

Q: How do I obtain my 6 digit provider identification number?

A: Please call Provider Relations (800) 235-3149.

Q: Will the "R" license be required?

A: Yes, for individual practitioners the "R" license is required. ("R" license means licensed in NYS with 6 years supervision)

Q: If a patient is allowed 20 visits per calendar year, do the visits used by MVP prior to 9/1/09 count towards the allowed amount?

A: Yes, all visits used prior to 9/1/09 will count.

Q: It was said that after 9/1/09 there are 8 pass through visits for treatment and 12 pass through visits for meds management. Do these apply for mental health services, chemical dependency services, or both?

A: 8 pass through visits apply for outpt SA and MH therapy codes. Pass through visits are per member per year.

For SOPS authorizations, precert is required or the provider can complete the request via the web using the ITR form.

Q: What happens for MVP authorizations ending 8/2/09 in the MVP system? If the prior authorized visits are used by 8/2/09, who is going to add new authorization for the month of August? Pass through visits may not suffice for the month.

A: If more then the prior authorized sessions are needed on previously authorized treatment from MVP, you should follow MVP current process for requesting additional sessions. They will be completing treatment requests until 9-1.

Q: For those providers who received the amendment assigning their MVP contract to ValueOptions®, will their reimbursement rates remain the same or will they receive another mailing with our fee schedule?

A: The provider should have received a fee schedule with the assignment mailing reflecting the rates.

Q: MVP currently has a "20 visit cap" for outpatient therapy is this going to change?

A: The member benefits will remain the same.

Q: Per the FAQ that Members seeing in-network providers are allowed eight (8) pass through visits per member per benefit year for therapy. An ORF (Outpatient Request Form) is required at this time. Is there anything additional we should add to this?

A: No that is correct an ORF is all that is required

Q: If you are already set up with Pay span with another insurance company are you automatically set up to receive payments through ValueOptions? If not, what is required to be set up? If you still want to receive checks from Value options, can you disable that feature?

A: All providers will receive registration letters to register with PaySpan for ValueOptions®. Yes – they will have to register ValueOptions® under the current account that they have setup. Please let them know if they have additional question in reference to setup to please contact PaySpan customer service which the phone number was posted in the PowerPoint presentation.

Q: How does VO know if an MVP member already used up their benefits for 2009/current benefit year?

A. MVP will be sharing that info with ValueOptions® and we will then share with providers

Q: Does the MVP benefit renew with the ValueOptions® management of MVP effective 09.01.09?

A. No

Q: What options are there for providers who cannot access Provider Connect/PaySpan once ValueOptions® stops issuing paper summary vouchers?

A. faxback

Q: Are other browsers other than Explorer supported for Provider Connect? If not, when?

A: No there are no other additional browsers that support ProviderConnect we are checking into this.

Q: Can a provider sign up for PaySpan for summary vouchers but not for claims direct deposit?

A: Yes

Q: Will ValueOptions® still issue checks once ValueOptions® stops issuing paper summary vouchers?

A: Yes

Q: Can a provider request an authorization online for meds & therapy at same facility/clinic?

A: Yes

Q: Can ValueOptions® confirm if med management from medical benes? (90862 does not come out of opmh benes)

A: Neuro-psych testing is MVP / psych testing is ValueOptions®

Q: Can a provider extend an auth online?

A: No, call ValueOptions® for auth end date extension. If try to extend auth online, may process as concurrent auth request

Q: Does the online auth approval give an end date for the auth?

A: Yes

Q: If auth extends over benefit year is it still valid?

A: Yes, but claims will pay against any pass-through visits before processing against any active auth

Q: Can you submit more then one DOS on the Provider Connect claims submission?

A: Yes

Q: Will IBM MVP be handled by ValueOptions®?

A: No, IBM MVP will remain with UBH for mental health services

Q: Will current INN ValueOptions® providers be able to see MVP members?

A: Current VO providers will receive correspondence to be able to see MVP members INN effective 09.01.09

Q: Can claims be submitted online through Provider Connect anytime?

A: Provider Connect claims submission is available 24 hours a day, 7 days a week

Q: Can multiple providers be set up under one login in Provider Connect?

A: Yes, Call VO EDI Helpdesk to set up

Q: Can a provider receive an authorization for more than one 90801 for member initiating treatment?

A: Providers that feel they need more than one 90801 can call Customer Service. Provider will be asked to give a time when he/she is available to receive a call back from a Clinical Care Manager and ValueOptions will evaluate the need for the additional 90801s. It is not an automatic and if it does not meet the criteria as identified below, the request will be sent to a ValueOptions peer advisor for review. Criteria are:

- 2) Child or Adolescent
- 3) Complex clinical presentation (i.e. not an ADHD evaluation)
 - a. Psychosis
 - b. Suicidality
 - c. OCD
- 4) Family involved in treatment
- 5) Co morbid Medical Issues