

MVP Health Care Frequently Asked Questions/General Information

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

A: ValueOptions® will administer the mental health and substance abuse benefits for MVP starting **September 1, 2009**. MVP has contracted with ValueOptions, Inc. (ValueOptions®) and its associated treatment providers to develop and maintain a comprehensive provider network. ValueOptions® will also process claims for behavioral health services and provide customer service support.

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

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

For provider contracting and credentialing questions, please contact ValueOptions® Provider Relations department at **1-800-235-3149**.

Q: I received a packet with an amendment to my provider contract with MVP Health Care. What do I need to do?

A: This document assigns your MVP Contract to ValueOptions® and to CHCS IPA, Inc., a wholly owned subsidiary of ValueOptions® and amends the contract to include provisions required by law and required pursuant to MVP's agreements with ValueOptions and CHCS IPA. Through this assignment and the amendments, your participation with MVP continues through participation with ValueOptions and CHCS IPA provider networks. Please note that these amendments and the contracts created apply solely to services rendered to MVP members. If the terms included are acceptable, you don't need to do anything. These amendments will take effect and become a part of your contract on the dates outlined in the amendments.

This means that for MVP Health Care members you are now a part of the ValueOptions® network. This does not apply to any other lines of business managed by ValueOptions®. If you are interested in participating with other lines of business with ValueOptions® or have questions about your status, please contact ValueOptions® Provider Relations at **1-800-235-3149**.

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

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

Q: What if I want to participate with ValueOptions for MVP Health Care only, what documents should I return from the packet of materials received?

A: For Providers new to ValueOptions:

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- a. *ValueOptions Practitioner Agreement with June 2009 Addendum and Exhibit 1-1 MVP Specific Provisions and ValueOptions, Inc. MVP Health Care Professional Fee Schedule – MVMA IPA MD Providers Only*
- b. *CHCS IPA Provider Services Agreement, with Exhibit E-1 MVP Health Plan Inc Specific Provisions and ValueOptions, Inc. MVP Health Care Professional Fee Schedule – MVMA IPA MD Providers Only*
- c. *Practitioner Credentialing Application and all Attachments*
- d. *Cover letter indicating that “This application is being submitted for participation with MVP Health Care books of business only”*

For Providers already participating with ValueOptions, but not CHCS IPA:

- a. *CHCS IPA Provider Services Agreement, with Exhibit E-1 MVP Health Plan Inc Specific Provisions and ValueOptions, Inc. MVP Health Care Professional Fee Schedule – MVMA IPA MD Providers Only*
- b. *Cover letter indicating that “This contract is being submitted for participation with MVP Health Care books of business only”*
- c. There is no need to do anything with the silent amendment to your *ValueOptions Practitioner Agreement* if you are accepting the addition of MVP Health Care provisions and fee schedule to the agreement. This amendment is effective thirty (30) days from the date of the cover letter regarding the amendment. Please keep the information for your records.

Transition of Care

Q: What is the transition of care plan for MVP members whose providers are participating in the ValueOptions® network on September 1, 2009, but whose authorizations from MVP expire on or before September 1, 2009?

A: For providers choosing to participate with ValueOptions® and CHCS IPA networks the following applies:
The transition of care benefit is in effect for up to 90 days for members in care prior to September 1, 2009. Providers will receive authorization for eight (8) outpatient visits and five (5) medication management visits during the 90-day transition period as a pass through. An Outpatient Review Form (ORF) or Medication Management form will be required once the eight (8) therapy sessions and/or five (5) medication management sessions are exhausted, or after 90 days, whichever comes first.

Q: What is the transition of care plan for members whose providers are not participating in the ValueOptions® network on September 1, 2009?

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A: For MVP providers who choose not to contract with ValueOptions and CHCS IPA, on September 1, 2009 the following transition of care timeframe will apply for medically necessary treatment:

The letters will be sent to members that are in current treatment with providers who are not in the ValueOptions® and CHCS IPA provider® networks to advise them of their transition of care rights.

- The transition of care period begins the day that an affected member receives a transition of care letter from MVP Health Care.
- The transition of care benefit is in effect for up to 90 days. Providers who are not in the ValueOptions® network will receive authorization for eight (8) outpatient visits and five (5) medication management visits during the 90-day transition period. An Outpatient Review Form (ORF) will be required once the eight (8) sessions are exhausted, or after 90 days, whichever comes first.

If a provider decides not to join the ValueOptions® and CHCS IPA networks and no out-of-network benefit is available, a member will need to transition to a network provider or the provider should seek approval for a Single Case Agreement (SCA) by contacting ValueOptions®.

Transition of care is designed to give the member the opportunity to complete treatment or to arrange transfer to an in-network provider when required by the MVP Health Care benefit plan. After September 1, 2009, please call ValueOptions® at the number on the member's MVP Health Care identification card and follow the prompts to verify the provisions and limitations of the member's benefit.

Authorization for Care Prior to and After September 1, 2009:

Inpatient Level of Care

- If you are treating an MVP member at an **Inpatient level of care** that requires telephonic authorization and the member was admitted prior to September 1, 2009, you will continue to review with MVP until step down. MVP will continue to manage that prior authorization and concurrent review reviews care until the member can be moved to a lower level of care.
- At the point any member that needs a step-down level of care; you must contact ValueOptions® to preauthorize this care on or after September 1, 2009.
- For inpatient care needed on or after September 1, 2009, providers will need to contact ValueOptions® for preauthorization of non-emergent admissions and preauthorization of post-stabilization care for emergency admissions. Please use the number on the back of the

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member's MVP identification card, and follow the appropriate telephone prompt for behavioral health care, or visit ProviderConnect at www.valueoptions.com/pclogin to authorize care. Telephonic review is available 24 hours a day, seven days a week.

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

- For members in alternative levels of care initiated and authorized by MVP Health Care prior to September 1, 2009, whose care needs to continue after September 1, 2009, you must contact ValueOptions® using the number on the back of the member's MVP identification card **or via ProviderConnect at www.valueoptions.com/pclogin by the last authorized date of the MVP authorization.**
- For alternative level of care needed on or after September 1, 2009, providers will need to contact ValueOptions® by calling the number on the back of member's MVP identification card and follow the telephone prompts for behavioral health care to be connected to ValueOptions® to authorize care.
- NOTE: Claims should be split depending on the dates of service:
 - Claims for dates of service on or before August 31, 2009 will need to be sent to MVP Health Care.
 - If the member continues in the same alternative level of care on and after September 1, even if the dates of service were authorized by MVP Health Care, the claims should be sent to the ValueOptions® claims address noted below.

Continued Stay review:

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

Outpatient Levels of Care

The member's benefit plan will define whether or not the member has coverage for out-of-network (OON) providers.

Outpatient out-of-network benefits require preauthorization. Providers or Members can call ValueOptions® Customer Service at the number on the back of the member's MVP Health Care identification card, following the prompts to connect to ValueOptions®. Two (2) sessions will be authorized after which an outpatient treatment review is required.

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.

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For physicians providing medication management sessions (90862) twelve (12) sessions per member per benefit year are allowed prior to required submission of the medication management form.

- Forms are available at www.valueoptions.com.
Forms may be submitted by using ProviderConnect at www.valueoptions.com/pclogin or via fax. Fax numbers will be those currently used by MVP Behavioral Health
Failure to submit the ORF and/or medication *management* forms may result in *non-payment* of claims.

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

Provider Network – Contracting and Credentialing

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

A: You will receive a letter from ValueOptions® regarding your network status, including any documentation. If you have any questions regarding your network status, please contact ValueOptions® at 1-800-235-3149.

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

A: ValueOptions® and MVP Health Care 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 ValueOptions® business rules for participation in the ValueOptions® and/or CHCS IPA provider networks. ValueOptions® will be notifying providers needed for the network via email and U.S Mail Postal Service. If you are requesting to be an in network provider with ValueOptions® please call ValueOptions® Provider Relations at 1-800-235-3149.

What Do I Do Next?

In the next 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. These updates will be available at www.valueoptions.com. If you have questions please call the ValueOptions® Provider Line at 1-800-235-3149.

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

A: Effective September 1, 2009, the ValueOptions® Fee Schedule you receive in your packet details the payment (by CPT Code and licensure) that you will receive for providing covered services to the MVP Health Care membership.

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- Q: My current Outpatient fee schedule is more favorable than ValueOptions' fee schedule. With whom do I discuss my ValueOptions® fee schedule?**
- A:** The ValueOptions® fee schedules for outpatient services are reviewed routinely and at present are determined to be competitive with other companies with similar business across the United States. In general, our fee schedules for outpatient services are non-negotiable.

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

Cathy Gilbert, Director of Provider Relations
ValueOptions®
433 River Street
Suite 4000
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: Do I have to be credentialed by ValueOptions®?**
- A:** Yes, all providers need to be credentialed by ValueOptions® to be included within the MVP Health Care/ValueOptions® and CHCS IPA provider networks. However, if you received contract amendments and a Notice of Assignment and Amendment letter from MVP Health Care assigning your contract to ValueOptions® and CHCS IPA, you will be notified by ValueOptions® when you are due for recredentialing based on the date you were last credentialed by MVP Health Care. Recredentialing is required every three (3) years.
- Q: I just completed my credentialing/recredentialing with MVP; can you accept the MVP 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.

However, if you received contract amendments and a Notice of Assignment and Amendment letter from MVP Health Care assigning your contract to ValueOptions® and CHCS IPA, you will be notified by ValueOptions® when you are due for recredentialing based on the date you were last credentialed by MVP Health Care. Recredentialing is required every three (3) years.

Online Services

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Q: What online services does ValueOptions® offer?

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

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

Claims

Claims for all dates of service prior to September 1, 2009 should be submitted to the claim address on the member's MVP identification card. Any questions regarding claims for these dates of service should be directed to the MVP Health Care 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 September 1, 2009, should be submitted to ValueOptions® at:

PO Box 1408
Latham, NY 12110

Any questions regarding claims on or after September 1, 2009 should be directed to ValueOptions® by calling the number on the back of member's MVP identification card and following the prompts to be connected to ValueOptions®.

MVP will be responsible for reimbursement of pre-certified inpatient admissions commencing prior to September 1, 2009 and any other services rendered **PRIOR** to September 1, 2009, therefore, please submit claims with dates of service prior to September 1, 2009 to the MVP address indicated on the member's identification card.

1. ValueOptions® will be responsible for reimbursement of pre-certified services rendered **ON or AFTER** September 1, 2009, by ValueOptions® participating providers. Please submit these claims to:

PO Box 1408
Latham, NY 12110

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 for dates of service on or after

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September 1, 2009?

- A:** Providers are required to bill on standard CMS 1500 and UB04 forms. Red ink forms should be used as these can be scanned, which expedites the claim entry into the claims system. The UB04 Form can only be used for inpatient and alternative levels of care for mental health and substance abuse, not outpatient professional mental health services. The CMS 1500 form should be used for outpatient professional services.
- Q: Can I submit my claims electronically to ValueOptions® for dates of service on or after September 1, 2009?**
- A:** Yes. CMS 1500 and UB04 (837P and 837I) electronic submissions are accepted according to guidelines contained in the ValueOptions® EDI materials found on www.valueoptions.com. If you are interested in electronic claim submission, please contact our ValueOptions® Electronic Claims Specialist at 888-247-9311. We strongly encourage providers to submit claims electronically for the efficiencies gained by both providers and in claims processing.
- Q: Does the ValueOptions® electronic claims format work with other claims clearing houses?**
- A:** Please contact our ValueOptions® EDI Helpdesk Coordinator at 888-247-9311. Please note: ValueOptions® does not reimburse for provider expenses associated with electronic claims submission.
- Q: When ValueOptions® authorizes care is the authorization an automatic guarantee of payment for services rendered?**
- A:** No, authorization of services is not a guarantee of payment. Payment depends on a number of factors including member eligibility, provider contract status, and benefit limits at the time care is rendered.
- Q: As an individual practitioner, billing outpatient services, do I need to include the provider number on my claims?**
- A:** Outpatient professional services must be billed on a CMS-1500 form. The following fields are required.

CMS-1500 required fields:

- | | |
|---|--|
| • Insured's ID number | telephone number |
| • Patient's name | • Patient status – married / single |
| • Patient's birth date and gender | • Is the patient's condition related to: Employment?
Auto accident? Other accident? |
| • Insured's name | • Is there another health benefit plan? |
| • Patient's address, city, state, zip code and telephone number | • Diagnosis or nature of illness or injury |
| • Patient's relationship to the insured | • Dates of service |
| • Insured's address, city, state, zip code and | • Place of service |



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- 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
- NPI

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

Q: For claims with dates of service on or after September 1, 2009, 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 1408
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.

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

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



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- Servicing provider name, service address & phone #
- Type of bill
- Federal tax number
- Statement covers “From” and “Through”
- Patient’s name (last, first, 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
- NPI



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- Provider Billing Address
UB-04 required field

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

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

A: Claims for Detox on Medical units should be submitted to MVP, regardless of when services are incurred.

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

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

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

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

Q: For dates of service on or after September 1, 2009, 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 the number on the member's MVP identification card and follow the prompts to be connected to ValueOptions®.

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. Information can also be submitted online using ProviderConnect.

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

A: Pre-authorization is required for all non-emergent services; however, after completing the evaluation, the provider should contact ValueOptions®. Please call ValueOptions® by dialing the number on the back of the member's insurance card 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: Clean claims submitted electronically within timely filing limits set out in your contract will be processed and paid or additional information requested where required within 30 days of receipt. Reimbursement for covered services shall be at the rates specified in the reimbursement in your contract.