



PROVIDER GUIDE FOR GHI ACCOUNTS

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INTRODUCTION

The ValueOptions® NY Provider Relations Team is proud to present this Provider Guide, specifically for the GHI accounts.

As part of our continuing commitment to our provider network, this guide was designed to make participation with our networks easier for both practitioners and facilities alike. Inside you will find valuable information about the GHI accounts including authorization processes and claims payment guidelines.

If you have any questions or comments about the material in this guide, feel free to contact Provider Relations at: (800) 235-3149, Monday-Friday, 9:00 a.m.-5:00 p.m., or via e-mail at: newyorkregion@valueoptions.com.

Thank you again for your continuing participation with ValueOptions®.

- New York Provider Relations

ABOUT THIS GUIDE

The information in this guide is applicable to the GHI-BMP, GHI-Medicare and GHI-Family Health Plus accounts only. For general information about other ValueOptions plans, please reference our Web site at:

www.valueoptions.com/providers/

OVERVIEW

WHAT ARE THE GHI PLANS?

GHI-Behavioral Management Program (GHI-BMP) is the term used for the mental health and substance abuse benefit plan for GHI members.

GHI-Medicare Choice PPO (GHI Medicare) is a Medicare-based managed care plan.

GHI-Family Health Plus (GHI-FHP) is a Medicaid-based plan located in several upstate NY state counties.

GHI AND VALUEOPTIONS®

Group Health Incorporated (GHI) is the insurance carrier and claims payer for mental health and substance abuse benefits for the GHI-BMP plan.

ValueOptions® is the program coordinator and utilization management (UM) company responsible for administrative tasks associated with these benefits. ValueOptions® is also the claims payer for the GHI Medicare and GHI-FHP plans.

GHI MEMBERS

Below is a sample card which patients use to identify themselves as a GHI member.



! TIP: Please be sure to get all the appropriate information from the member's benefit card prior to treatment, including: name, date of birth, address and group number.

PLAN PARTICIPATION

REFERRALS & STANDARDS

All GHI members have access to a Clinical Referral Line (CRL), staffed with licensed clinicians, 24 hours a day, 7 days a week.

In order to ensure the highest possible quality of care for our members, the following referral standards have been established:

Risk Rating 1 - Moderate/Mild Risk, Routine (10 business days)

- A. When the member demonstrates some distress, but the precipitants of the distress and associated stressors can be easily identified and/or
- B. When the member manifests an adequate to good pre-morbid level of functioning with continuing adequate social/family supports and resources and/or
- C. When the member demonstrates mild impairment in judgment, functioning and/or impulse control and/or
- D. When a member's request can be addressed safely within 10 business days, it is considered to be a Risk Rating 1 – Moderate/Mild Risk (Routine).

Risk Rating 2 - Serious Risk, Urgent (24 hours)

- A. The member is upset and distressed but not in immediate danger of harm to self or others, there is evidence of adequate pre-morbid functioning but social/family supports have significantly changed or diminished and/or
- B. The member is displaying moderate impairment in judgment, impulse control and/or functioning which is expected to further diminish and/or
- C. The member indicates intoxication or the risk of withdrawal and/or
- D. The member indicates an urgent need to be seen

Risk Rating 3 – Emergency (Immediate)

- A. Failure to obtain *immediate* care would place the member's life, another's life, or property in jeopardy, or cause serious impairment of bodily functions, or
- B. Member/caller indicates that failure to obtain *immediate* care would place the member's life, another's life or property in jeopardy, or cause serious impairment of bodily functions, or
- C. There exist severe medical complications concurrent with or as a consequence of psychiatric or substance abuse illness and its treatment.

- Appointments for life-threatening emergencies are available immediately.
- Appointments for non-life-threatening emergencies are available within 6 hours.
- Urgent appointments are available within 48 hours.
- Routine appointments are available within 10 business days.

YOUR PRACTICE PROFILE

Your ValueOptions® provider file is not only used to make referrals of patients to you, but also important correspondence, and claims payment.

It is therefore very important that we have the most up-to-date information on file for you at all times.

Any changes or updates to your provider record must be submitted in writing to the appropriate address or fax listed below:

Individual Practitioners:

ValueOptions®
c/o Practitioner Maintenance
P.O. Box 370
Latham, NY 12110

Fax: (518) 220-8483

Facilities:

ValueOptions®
c/o Facility Maintenance
P.O. Box 4080
Virginia Beach, VA 23454

Fax: (757) 412-6534

QUALITY REVIEWS

As part of a routine audit process, our Quality Management team may periodically request access to treatment records for select GHI members for whom you are providing treatment.

If requested, please supply copies of the requested records and forward them to the Quality Management department within five (5) business days.

Records will be treated confidentially and destroyed after the review process is complete.

! NOTE: Release from the patient is not required in order to provide copies of these records to ValueOptions®. HIPAA regulations allow release of records without consent in order to support operations of health care and quality reviews.

BALANCE BILLING

The process known as “balance billing” is when an in-network provider knowingly bills an eligible ValueOptions® member for any coverable service beyond the applicable co-payment or co-insurance.

Please note that the process of balance billing is prohibited by your ValueOptions® Individual Practitioner Agreement.

INITIAL EVALUATIONS (90801)

An initial diagnostic evaluation (CPT code 90801) is allowed only once per patient, per calendar year.

Contracted mental health clinics can bill for two (2) initial diagnostic evaluations (90801) — one for the psychiatric evaluation and one for the psychosocial assessment.

AUTHORIZATION

OUTPATIENT MENTAL HEALTH

Initial Certification and Continued Care

The beginning of the year/initial case registration is no longer required. You will only be required to submit claims for the initial ten (10) outpatient mental health sessions. These “pass-through” visits are available each calendar year.

For **GHI-BMP members** - ten (10) sessions are available for all members with the exception of psychological testing, which will continue to require pre-certification. This includes one (1) 90801 evaluation and nine (9) follow-up sessions.

For **GHI Medicare members** - five (5) sessions are available for members. This includes one (1) 90801 evaluation and four (4) follow-up sessions for new members or five (5) follow-up sessions for existing members.

For **GHI-FHP members** - all sessions must be pre-certified before the beginning of treatment.

Continuing Treatment

If treatment will continue beyond any initial pass-through sessions, additional visits must be authorized.

There are several ways to authorize additional visits:

- Request additional visits online via the Web-based ProviderConnect service, located at www.ValueOptions.com
- Fax a completed Outpatient Review Form (ORF2) or Medication Management Form at least 2 weeks prior to the utilization of the last visit currently authorized.
- Mail a completed Outpatient Review Form (ORF2) or Medication Management Form at least 2 weeks prior to the utilization of the last visit currently authorized.



Tip: All clinical forms should be sent to:

ValueOptions®/GHI
P.O. Box 1884
New York, NY 10116-1884

-OR-

Fax: (212) 560-7778

Psychological Testing

Psychological testing is a pre-certified-only benefit.

For testing, a Psychological Evaluation Request Form listing the tests and number of hours requested is required for approval. GHI-BMP will review for medical necessity and notify you in writing of their determination.

If the testing is to determine medical readiness of a medical procedure, GHI-BMP can authorize a maximum of one (1) 90801 and three (3) 96101, 96102 or 96103's.

Neuropsychological Testing

CPT procedure codes 96105, 96110, 96111, 96116, 96118, 96119 and 96120 are covered and processed under the GHI medical contract, and does not require GHI-BMP authorization. GHI will pay for up to 12 hours of neuropsychological evaluations. Additional hours will be subject to a medical necessity evaluation.

Electro-Convulsive Therapy

CPT procedure codes 90870 is covered as a medical/surgical benefit and does not require pre-certification through ValueOptions®.

OUTPATIENT SUBSTANCE ABUSE

Outpatient Substance Abuse services are authorized the same way as higher level of care (HLOC) programs are. Please see the next section for details.

HIGHER LEVELS OF CARE (HLOC)

Requests for outpatient substance abuse and higher levels of care are reviewed by ValueOptions® Clinical Care Managers (CCMs) utilizing ValueOptions® clinical criteria (located at www.ValueOptions.com) for mental health treatment, and the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC2R) for substance-abuse related treatment.

If the member has a different primary insurer (other than GHI), no pre-certification is required.

To receive authorization, please call the appropriate customer service number listed below:

GHI-Behavioral Management Program (866) 271 - 6403

GHI Medicare Choice PPO (866) 318 - 7595

GHI Family Health Plus PPO (866) 801 - 5367

Emblem Health (866) 208 - 1424

You will be connected to a ValueOptions® Customer Service Representative to verify basic information such as: facility tax ID#, location of service, patient eligibility, and coordination of benefits information.

A Clinical Care Manager (CCM) from the care management department will contact you back to begin the clinical review process.

ABOUT VALUEOPTIONS® CLINICAL CARE MANAGERS

ValueOptions® places a high value on the selection, training and performance evaluation of clinical staff performing utilization management services. All staff involved in clinical care management activities hold degrees and licensure in their field. ValueOptions® requires that Clinical Care Managers (CCMs) be fully licensed mental health professionals with a minimum of three years prior clinical experience in a mental health/substance abuse setting providing direct patient care.

PEER ADVISORS

ValueOptions® CCMs conduct medical necessity reviews utilizing ValueOptions® clinical criteria (located at www.ValueOptions.com) for mental health treatment, and the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC2R) for substance-abuse related treatment.

If the CCM is unable to approve the proposed treatment under ValueOptions® criteria, the case will be referred to a Peer Advisor (PA) to perform additional review:

- The PA will make a decision as to the medical necessity of the requested care.
- If there is a lack of information to make a medical necessity decision, ValueOptions® will notify the provider of the required information. This could require submission of documents or a verbal peer-to-peer review.
- If a response is not received in a timely manner from the provider, a PA may render a non-certification based on the information that is available.

! NOTE: A non-certification based on medical necessity will only be rendered by Peer Advisors.

APPEALS

CLINICAL APPEALS

Any non-certification or modification of the treatment requested due to medical necessity reasons is considered an adverse determination and eligible for a clinical appeal.

A clinical appeal can be initiated by the enrollee, the enrollee's designee, or the provider via phone, fax or in writing.

Please note that the GHI-BMP and GHI-FHP plans only have one level of internal appeal.

GHI-BMP - Must be requested within 180 days of the initial adverse determination.

GHI-FHP - Must be requested within 60 days of the initial adverse determination.

GHI Medicare - ValueOptions® is not delegated to handle appeals for this plan. Please refer to the adverse determination letter for appeal instructions or contact GHI directly at (866) 557-7300.

When the appeal review is completed, ValueOptions® will inform the provider of the decision.

! TIP: To view ValueOptions® Clinical Criteria or to see more details about the appeal process, please reference the Provider Handbook located online at:

www.ValueOptions.com

CLAIMS APPEALS

To appeal specific claims denials, please see below:

GHI-BMP:

- Login to *myGHI* for providers at: www.ghi.com
- Call GHI at (800) 358-5500 between the hours of 9:00 a.m.-5:00 p.m. EST, Monday-Friday.
- Submit written inquiries (including supporting documentation) to:
GHI-BMP Claims
P.O. Box 2828
New York, NY 10116-2828

GHI-FHP:

- Call the Claims Customer Service Department at (866) 424-3195.
- Submit written inquiries (including supporting documentation) to:
GHI-FHP Claims
P.O. Box 1347
Latham, NY 12110

GHI Medicare:

- Call the Claims Customer Service Department at (866) 424-3195.
- Submit written inquiries (including supporting documentation) to:
GHI-FHP Claims
P.O. Box 1377
Latham, NY 12110

CLAIMS & BILLING

TIMELY FILING

To be considered for payment, all claims received must be “clean claims.”

A clean claim is a UB-04 or CMS-1500 claim form submitted by the provider for health care services rendered to a covered member, complete and free of defect.

! TIP: For Outpatient Mental Health claims, submitting a red ink CMS-1500 form allows for quicker, more accurate processing.

Claims for GHI members must be submitted within the following timeframes:

GHI-BMP is the Primary Insurer

Claims must be submitted to GHI within 365 days of the date of service. For example, if services were provided on January 12, 2008, claims must be received by January 12, 2009.

GHI Medicare or GHI-FHP is the Primary Insurer

Claims must be submitted to ValueOptions® within 180 days of the date of service. For example, if services were provided on January 12, 2008, claims must be received by July 11, 2008.

! TIP: An extensive listing of billing codes is included as part of the ValueOptions® Provider Handbook and is located online at: www.valueoptions.com/providers/handbook.htm

ELECTRONIC CLAIMS

Filing claims electronically has many advantages over paper claims submission:

- Rapid submission leads to faster reimbursement
- Elimination of paperwork and easier record-keeping
- Cost-saving over submitting on paper

For the **GHI-BMP** plan, participating providers, can submit claims electronically to GHI via the Electronic Media Claims (EMC) process.

For the **GHI Medicare** and **GHI-FHP** plans, participating providers can submit claims electronically to ValueOptions® via free Electronic Data Interchange (EDI) software.

To enroll in the EMC program for **GHI-BMP** claims, please contact a GHI-EMC representative at: **(212) 615-4EMC**
or visit **www.ghi.com**

To begin submitting electronic claims for the **GHI Medicare** and **GHI-FHP** programs, please contact the EDI Helpdesk at: **(888) 247-9311**
or visit **www.ValueOptions.com**

SINGLE CLAIMS SUBMISSION

An even more convenient way to submit claims for either the GHI Medicare or the GHI-Family Health Plus plan is to submit single claims online via the Web using the ValueOptions® ProviderConnect service.

To sign up for this convenient service, please visit the provider section at:
www.ValueOptions.com

MEDICARE PRIMARY CLAIMS

When a GHI-BMP member has Medicare as their primary insurance, claims must be submitted to Medicare first before payment from GHI or ValueOptions® will be considered. The Medicare Explanation of Benefits must be attached to the claim for the claim to be paid.

If you do not participate with Medicare, either a denial of services or opt-out letter from Medicare is required or the claim will be denied. Because of this requirement, Medicare primary claims cannot be submitted electronically by the provider.

REIMBURSEMENT

All in-network practitioners will be reimbursed according to the agreed-upon Fee Schedule, less any applicable co-pay (if any). Payments will be made in accordance with NY State Prompt Pay guidelines.

Only one (1) professional visit per day per provider will be paid. Clinics can bill two (2) professional visits per day as long as a psychiatrist conducted one of the visits.

EFT (ELECTRONIC FUNDS TRANSFER)

Instead of receiving a paper check, you can sign-up to have GHI-BMP claims payments sent electronically directly into your bank account.

For more information or to enroll, please call (212) 615-4773.

INDIVIDUAL PROVIDER CLAIMS

Outpatient Mental Health claims for individual providers should be submitted on a red-ink CMS-1500 claim form. The following minimum information is required to be considered a complete clean claim:

- Subscriber's ID/certificate number
- Last name and first name of subscriber
- Patient's first name
- Patient's date of birth
- Patient's address
- Relationship to subscriber
- DSM-IV diagnosis
- CPT procedure code(s) for each date(s) of service
- Date(s) of service
- Number of visits
- Type of service
- Place of service
- Your charge for each service line
- Total charges billed
- Tax identification number
- National Provider Identifier (NPI) number
- Name and address of facility where services were rendered (Box 32)
- Physician supplier's billing name, address, zip code and phone (Box 33)
- Rendering physician's signature
- Primary carrier's EOB (if applicable)

If the claim is a resubmission of previously denied services, please indicate on the claim that it is a resubmission. Please do not add new services that were not included on the original claim, these should be submitted separately.

FACILITY CLAIMS

Facility paper claims for all levels of care should be submitted on a UB-04 claim form (a CMS-1500 form is acceptable for outpatient mental health services only). Special attention should be paid to the following:

- The facility name and address must appear on the UB-04 in Box 1
- The dates of service must match the dates authorized, and there must be a period start and end date in Box 6
- The facility TIN must appear on the UB-04 in Box 5
- The facility’s National Provider Identifier (NPI) number must be listed
- The revenue and/or CPT codes must match the services authorized, and appropriate CPT/Revenue code descriptions must match the codes used
- For facilities that bill outpatient services on a UB-04, you must use both revenue and CPT codes
- You must be contracted for the services for which you are billing

If the claim is a resubmission of previously denied services, please indicate on the claim that it is a resubmission. Please do not add new services that were not included on the original claim, these should be submitted separately.

CLAIMS ADDRESSES

Paper claims can be submitted to the appropriate address listed below:

GHI-BMP Claims		
Outpatient MH Claims: GHI-BMP Claims P.O. Box 2827 New York, NY 10116-2827	Other Levels Of Care: GHI Attn: Hospital Claims P.O. Box 2833 New York, NY 10116-2833	GHI Employees: GHI-BMP Attn: Employee Claims P.O. Box 2861 New York, NY 10116-2861
GHI Medicare Choice PPO Claims		GHI Family Health Plus
All Claims: ValueOptions® P.O. Box 1377 Latham, NY 12110		All Claims: ValueOptions® P.O. Box 1347 Latham, NY 12110

TIPS FOR AVOIDING ADMINISTRATIVE CLAIMS DENIALS

ValueOptions® and GHI are committed to the efficient processing of your claims. Therefore, the following claim submission tips were created based on the most common administrative denials:

1. **Service Was Not Authorized** - GHI-BMP and GHI Medicare allow several visits with a new patient to pay automatically. If treatment is to continue beyond the initial sessions, an Outpatient Review Form (ORF2) must be submitted. (See page 5 for more information.)
2. **Duplicate Claims** - ValueOptions® strives to have 100% of all claims processed within 25 days. If you have not received notification within 25 days, please take the following steps prior to submitting a duplicate claim:
 - Check the claim status via the *ProviderConnect* online application at www.ValueOptions.com.
 - Call Customer Service at one of the numbers listed on page 7
3. **Itemized Bill is Needed** - Please ensure the following elements are included when submitting a claim:
 - Dates of service should be listed individually on the CSM-1500 claim form (no date spans)
 - Date ranges can be used on UB-04 forms if care is consecutive and the same procedure
 - Valid DSM IV diagnosis code
 - Rendering provider, provider billing information and NPI number entered in appropriate areas of UB-04 and CMS-1500 forms
 - Appropriate and valid place of service codes with correlating appropriate and valid CPT codes
 - Accurate member and/or patient information including member identification number, patient name and date of birth
4. **Authorization and Claim Do Not Match** - The services billed must correspond with the care that was registered and authorized.
5. **Timely filing** - Claims must be submitted to GHI or ValueOptions® within the timely filing guidelines listed on page 11. If the patient's GHI coverage is not the primary insurance, the primary carrier's EOB must be attached to the claim.

PROVIDERCONNECT

The ProviderConnect application is an entire suite of Web-based online tools designed to streamline as many of the administrative requirements of participation as possible.

ProviderConnect allows you to:

- Check the status of your claims, showing how much was paid and when
- Look up your patient's eligibility both currently and in the past
- See benefit information for your GHI patients. Co-pay amounts and deductibles are listed for both in-network and out-of-network care
- Check authorizations and print authorization letters
- Send an inquiry to customer service and receive a response within 5 days
- Enter an authorization request online
- Submit single claims for the GHI Medicare and GHI Family Health Plus plans

**All online and in real-time,
24 hours a day, 7 days a week!**

SIGN-UP

To get started with the ProviderConnect service, simply go to www.ValueOptions.com and click the "Providers" button. Next, click the "Register" button and fill out the simple online form.

TECH SUPPORT

If you need help registering or logging on, please contact our e-Support Services at (888) 247-9311 or e-mail: e-supportservices@valueoptions.com

! TIP: To register for ProviderConnect, you will need your 6-digit ValueOptions® provider ID# or your 7-digit GHI PIN#. If you do not know either of these numbers, please call Provider Relations at:

(800) 235-3149

ACHIEVE SOLUTIONS®

AchieveSolutions® is designed to help you engage your patients to actively participate in their own treatment and recovery. ValueOptions® offers you access to credible clinical content, featuring nearly 4,000 articles on over 200 topics including: depression, stress, anxiety, substance abuse, relationships, grief, parenting/elder care and workplace issues. This site includes news items, interactive calculators and quizzes, trainings and other resources.

Information can be printed and shared with your patients during office visits or you can refer your patients directly to the site. A Spanish version of the site is also available.

To access this site, go to www.achievesolutions.net/providers. You can also access ValueOptions® Provider Referral Search (ReferralConnect), a fully searchable online directory that displays a list of network providers and facilities throughout the country.

FORMS

For your convenience the most frequently used ValueOptions® forms are available for viewing and printing online at www.ValueOptions.com, including:

- Change of address forms
- Substitute W-9 forms
- Outpatient Registration Forms (ORF2)
- Medication management registration forms and many more

CONTACT

To contact ValueOptions®, please refer to the list of phone numbers and/or e-mail addresses below:

Customer Service

- Member information (benefits, eligibility, etc.)
- Appeals and grievances

GHI-BMP: (866) 271-6403
GHI Medicare: (866) 318-7595
GHI-FHP: (866) 801-5367

Claims

- Claim status/questions

GHI-BMP: (800) 358-5500
GHI Medicare: (866) 424-3195
GHI-FHP: (866) 424-3195

Provider Relations

- Provider contract status/questions
- Provider complaints

(800) 235-3149
nyregion@valueoptions.com

National Networks Provider Line

- Provider demographic updates (address, tax ID number, etc.)
- Credentialing/re-credentialing status

(800) 397-1630

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Improving Behavior to Improve Health

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