ValueOptions, Inc. New York City Engagement Center Provider Relations Frequently Asked Questions

Provider Services:

Q. How do I contact ValueOptions, Inc. for any questions I have related to NYC Engagement Center business?
A. Please call ValueOptions, Inc. by dialing the number on the back of the Member's insurance card. You can also call our Provider Line at (866) 477-9741. Depending on the nature of the call, the menu choices will direct you accordingly. You may also fax us information at (212) 560-7629. Our mailing address is ValueOptions Inc., P.O. Box 1884, New York, NY 10116. In addition, you can contact Provider Relations via email at newyorkregion@ValueOptions.com.

Q. As a Provider, how will I receive updates, changes, new policies or guidelines?
A. You may access the ValueOptions® Provider Handbook as well as any new updates on the web site at www.ValueOptions.com. In addition, ValueOptions, Inc. may distribute mailings to providers when appropriate. A provider newsletter is also published 3 times a year as well.

Q. If I am a ValueOptions, Inc. provider, how do I know which ValueOptions, Inc. accounts I am participating with as an "in-network" provider?
A. Several of our accounts have specific provider networks. If you are not sure which network you are contracted to participate with, you may contact the ValueOptions, Inc. Provider Relations line directly at 866-477-9741.

Q. How do I join the ValueOptions, Inc. network?
A. Please submit a Letter of Interest with the following key information. Please note questions 1 – 3 are required in order to join the network, and must be documented in your letter. 1) Do you have 3 years post licensure experience?* 2) Did you graduate from an accredited college?* 3) Do you have liability insurance with the following specification: 1 million/3 million; Individual/Aggregate?*

- Name
- Social security number
- Date of birth
- Tax ID number (if different from your social security number)
- Practice address
- Practice county
- Phone number
- Specialties (if any)
- If you are an MD, note whether you are board certified in child/adolescent, adult or both
- Copy of your curriculum vitae
- Copy of your license

Your letter of interest will not be reviewed without receipt of all requested information in its entirety. In response to your Letter of Interest, you will either receive a credentialing package in the mail, requesting that you join the network, or a letter stating that we are not currently recruiting in your area. Please note:

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network recruitment is based on geographical need.

Q. Is a Provider listing available on the ValueOptions, Inc. web site?
A. No. The ValueOptions, Inc. networks are proprietary and often client specific. However, some of the ValueOptions, Inc. provider panels are available on client websites. If you are looking for other in-network providers, please call ValueOptions Inc. by dialing the number on the back of the members' card and follow the prompts to speak with a member/customer service representative.

Q. When an outpatient practitioner joins an already contracted facility, does the new practitioner need to be credentialed before seeing members?
A. No. Employees of contracted facilities do not require credentialing to provide outpatient services. In order for VO to maintain up to date provider information, and be able to refer member appropriately, facilities should submit a new Practitioner Profile form for each new practitioner, as well as an updated staff roster on a quarterly basis.

Q. I have submitted a credentialing application, what is the status?
A. Please call National Network Operations at 800-397-1630.

Q. I am in the recredentialing process, what is the status of my recredentialing application?
A. Please call National Network Operations at 800-397-1630.

Q. How do I update my provider billing address, practice address or a change in my tax id number?
A. You will need to complete a "Change of Address" form and a new "W-9 form". These forms can be found in your Provider Handbook or in the forms section located on our website at www.ValueOptions.com. Fax all changes to (757) 412-6089, Attention: Central Maintenance. The forms can also be mailed to: ValueOptions Inc. Attention: Central Maintenance, P.O. Box 4575, Virginia Beach, VA 23454.

Q. I have opened up a new service location. Can I have a separate billing and mailing address?
Providers may have multiple service locations, however you may only list one mailing address and one billing address.

Q. How do I get a ValueOptions Inc. Provider Handbook?
A. Please visit our website www.ValueOptions.com, or call 800-397-1630.

Q. What if I cannot meet the seven calendar day standard to see a member for routine outpatient care?
A. As part of ValueOptions, Inc. efforts to obtain NCQA accreditation and as part of your Provider agreement, you are required to offer a member an appointment for routine outpatient care within seven (7) calendar days of request. If you are regularly unable to offer appointments within this timeframe, please let the referral source know so that another outpatient therapist may be found. You will also need

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to notify ValueOptions, Inc. of your inability to offer an appointment within 7 days. This will enable us to monitor providers who may have more volume/referrals than they can accommodate, and work to ensure better access for our members.

Member Services

Q. When I call to verify Member eligibility, how can I be sure I am getting the most up to date information?
A. ValueOptions, Inc. is contracted to receive updated eligibility information on a regular basis from all accounts. This varies by account – but most provide either weekly or monthly eligibility updates.

Q. How do I check eligibility benefits?
A. Network Providers may verify Member eligibility using the ValueOptions, Inc. dedicated toll-free 800# for the member's account. The 800# should appear on the back of the member's card or call 800-692-2489.

Q. Can a provider balance bill a member if the provider determines that a member has exhausted his/her benefit?
A. This is not balance billing. It is the provider's responsibility to inform the member of the costs of services in the event the member is not eligible or has exhausted his/her benefit. It is the provider's responsibility to have a written policy of conditions under which the provider might seek monies directly from the member, and the costs of services. It is the provider's responsibility to have the member sign such an agreement BEFORE rendering treatment. For more information about balance billing, please consult your provider handbook or visit us at www.ValueOptions.com to review a copy of the Provider Handbook.

Q. Can a provider balance-bill a member if it is determined that the eligibility information provided by ValueOptions® was incorrect?
A. The term 'balance bill' is incorrect here. This question has more to do with entering into a 'private agreement' with the member, whereby the member will be responsible for ALL charges in situations when the member is not eligible. The provider has recourse to collect, because essentially the member was not eligible. Providers are responsible for providing members with a written policy outlining conditions under which they might seek monies for the costs of services. It is also the provider's responsibility to have the member sign such an agreement BEFORE rendering treatment.

Q. What if ValueOptions, Inc. pays the claim and later finds out a member is ineligible; do you go back to the provider and collect?
A. Yes. Please refer to your Facility Agreement or your Practitioner Agreement.

Q. If a member whom I have seen is showing as not eligible and the claim was denied, but later found to be eligible, what can I do?
A. You may file a complaint. Please send appeals to: ValueOptions Inc., Attention:

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Complaints/Grievances, P.O. Box 1347, Latham, NY 12110.

Claims and Billing

Q. What paper forms can be used for claims submission?
A. The UB92 Form and the CMS 1500 Form. The UB92 Form can only be used for inpatient and alternate level of care for mental health and substance abuse (not outpatient mental health). The CMS 1500 should only be used for outpatient mental health.

Q. Can I submit my claims electronically to ValueOptions, Inc.?
A. Yes. For accounts in which ValueOptions, Inc. pays the claims CMS 1500 and UB92 electronic submissions are accepted, according to guidelines contained in ValueOptions, Inc. EDI materials. If you are interested in electronic claim submission, please contact our ValueOptions Electronic Claims Specialist at 888-777-4742. For GHI-BMP claims submissions, please call 212-615-4EMC. If you are unsure which accounts ValueOptions Inc. pays the claims, please contact Provider Relations at 866-477-9741.

Q. Does the ValueOptions, Inc. 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, Inc. does not reimburse for provider expenses associated with electronic submission.

Q. When VO 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. When I submit a claim, how long will it take to be paid?
A. ValueOptions, Inc. will process a "clean claim" (i.e. complete, error free) within forty-five (45) days of receipt. Providers have an additional 60 days to appeal a claim response. Providers who submit electronic claims, will have faster processing of their claims.

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

A. Yes, include the provider number in block 33 of the CMS 1500 form and completely and accurately fill out blocks 31, 32, and 33 on the CMS 1500 Claim form.

Q. As a facility billing for outpatient services, do I need to put the provider number on my claims?

A. Yes. If you are a Facility billing for outpatient services only, billing by populating block 33 (PIN #on the CMS 1500) forms and Block #82 on the UB 92 form. Additionally, you need to fill out Block 31, 32, and 33 on the CMS 1500 form and Block 51 of the UB 92 form.

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

A. Use the provider number in Block 33 GRP on the CMS 1500 form and Block 51 of the UB 92 form. Use the revenue codes for each specific service listed on the Exhibit A of the facility agreement.

Q. Can a Provider bill for telephonic therapy sessions?

A. ValueOptions, Inc. will not reimburse for any telephonic services provided to a member.

Q. Can I bill for the time it takes to complete PCP documentation for my client?

A. This is NOT a billable service. PCP documentation should be part of your normal documentation procedures. It is a "best practice" standard, and strongly encouraged that a provider contact a member's PCP (with the proper consent), or other treating Providers, to ensure coordination of care and quality of treatment.

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.

Q. Can a provider bill using ICD-9 codes?

A. Yes. Claims payments are programmed based on DSM-IV and ICD-9 codes.

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

A. When the seriousness of the medical condition is such that an admission to a medical unit is required, and medical carrier authorizes it, the expense shall be a medical expense and will not be the financial responsibility of the behavioral health plan. The medical carrier will process these claims.

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), the behavioral health plan will need to review and authorize the care. ValueOptions, Inc requires pre- and concurrent authorizations.

Q. Who is responsible for members admitted to a behavioral health unit with medical issues that need to be treated?

A. If medical care is necessary for a member on a behavioral health unit, the medical care is the responsibility of the medical plan. The provider should contact the medical carrier before performing any medical procedure, as preauthorization may be required.

Q. Where do I go to have a claims question/issue resolved?

A. Please call ValueOptions Inc. by dialing the number on the back of the member's insurance card and

selecting the prompt for the Claims Customer Service department.

Clinical, Authorization and Quality Services

Q. Are outpatient mental health authorizations required for GHI-BMP/EmblemHealth EPO/PPO members?
A. Provisions in the Federal Mental Health Parity (FMHP) legislation make pre-authorization and pass-through visits unnecessary. There is no longer a pre-authorization requirement for members enrolled in the GHI/EmblemHealth City of New York employee and the DC 37 Union plans along with their dependents effective 7/1/2010. ValueOptions® will also continue its focus on those members diagnosed with complex mental health and substance abuse illnesses. Although no precertification of the outpatient services these complex patients receive will be required, ValueOptions® will be contacting the treating provider early in these patients' treatment regimen in order to develop, in conjunction with the provider, an individualized plan of care which may involve some reporting of the patients status similar to the ORF (Outpatient Review Form) that was previously used. The goal of this process is to insure, in cooperation with the provider, the best possible outcome for the patient. In place of the previous pass through/preauthorization outpatient processes, ValueOptions® has initiated an outlier care management model. This outlier model will focus on individual cases by diagnostic category where the course of treatment varies significantly from expected norms.

Q. When should I submit my Outpatient Review Form (ORF)?
A. The Outpatient Review Form only needs to be submitted to ValueOptions® when a provider is specifically instructed to do so.

Q. Where do I send the Outpatient Review Form?
A. Fax them to 212-560-7778 or mail them to ValueOptions Inc., P.O. Box 1884, New York, NY 10116

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

Q. As an inpatient provider, do I have to pre-authorize an admission?
A. ValueOptions, Inc. will only consider a member eligible for an admission if: 1). A face-to-face evaluation of the member has occurred. 2). The member meets the Medical Necessity criteria for the requested level of care.

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, the provider after completing the evaluation should contact ValueOptions, Inc. Please call ValueOptions, Inc. by dialing the number on the back of the member's insurance card to review the emergency situation, what services are offered, and the clinical information. This includes nights, weekends, and holidays, as our phone lines are open 24 hours a day.

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Q. Do emergencies require pre-authorization?
A. Yes. Pre-certification is required for all services. However, after completing the evaluation providers should contact ValueOptions, Inc. to conduct a telephonic utilization review. Please call ValueOptions, Inc. by dialing the number on the back of the member's insurance card to review.

Q. Where do I learn about ValueOptions, Inc. Medical Necessity criteria and the different levels of care?
A. The ValueOptions, Inc. Provider Handbook contains detailed information of our Medical Necessity criteria for mental health care. This can also be found on the ValueOptions, Inc. web site, www.ValueOptions.com. For substance abuse services, ValueOptions, Inc. has adopted the proprietary ASAM criteria that can be found at, www.ASAM.org.

Q. Why does a Provider have to report adverse incidents? Is this a violation of confidentiality?
A. Reporting adverse incidents is not a violation of confidentiality. Adverse incidents are occurrences, which represent actual or potential serious harm to the well being of the member or to others by the member, while the member is in treatment with a provider. It is incumbent upon ValueOptions, Inc. to ensure every member's safety. ValueOptions® will work with the provider to improve the safety of members in any level of care.

Q. What diagnosis code do I submit when I perform an initial evaluation, as there is no real diagnosis made at that time, yet I want to be paid for the evaluation?
A. A claim will not pay without a DSM-IV or ICD 9 diagnosis code. ValueOptions, Inc. suggests that you provide a NOS diagnosis.

Q. What if my patient is in a rehabilitation facility/hospital and I need to perform neuropsychological testing to rule out a behavioral diagnosis?
A. For members admitted to an intensive level of care for a medical condition, but who also have a concomitant behavioral health/psychiatric diagnosis, neuropsychological testing is covered benefit under the medical benefit. However, it is typically included within the facility contract.

Q. Does a psychiatric consult on a medical floor have to be preauthorized?
A. Providers performing psychiatric consults must register the member within 24 hours of the service by calling the number on the back of the members' card.

Q. Who pays for ambulance transportation?
A. Medically necessary ambulance services are the responsibility of the medical carrier. However, should ambulance transportation be necessary for a behavioral health issue, ValueOptions, Inc. will be able to provide the provider with additional information. Please call ValueOptions, Inc. by dialing the number on the back of the member's insurance card.

Q. Will ValueOptions, Inc. authorize an evaluation or treatment if it is court-ordered?
A. Court-ordered evaluation/treatment may be covered depending on the benefit plan. All court-ordered

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evaluations/treatment must be preauthorized.

Q. Will ValueOptions, Inc. deny care if a provider misses a scheduled Utilization Review appointment?
A. ValueOptions, Inc. makes every effort to connect with providers to complete the review process. If a missed review is not rescheduled within 24-hours, ValueOptions, Inc. reserves the right to issue an Administrative denial for failure to provide clinical information.

Q. Where do I send Appeals, Complaints & Grievances?
A. Please send them to ValueOptions Inc., Attention: Complaints/Grievance Department, Box 1347, Latham, NY 12110

Q. Who will pay for the External Review Process in the event there is a cost associated with the Review?

A. The responsible party for payment and the actual costs vary by state. Contact the Medical Affairs Department Appeals Coordinator at ValueOptions, Inc. at 212-560-7608.

Q. What should a provider do if a member refuses to allow his/her clinical records to be reviewed for a quality audit?

A. ValueOptions, Inc. understands and values the confidentiality of member's records. For the purpose of quality audits, ValueOptions, Inc. will accept charts which have been blinded by "whiting out" or by "blacking out" the member's name.

Q. Do I have to get preauthorization for psychological or neuropsychological testing?

A. Contracted providers are required to complete a Request for Authorization for Psychological Testing Form before rendering testing services. This form must be faxed to 212-560-7778 or mailed to Box 1884, New York, NY 10116. The Provider and member will be notified of the disposition of the request within three (3) business days of receipt of the request.

Q. Does psychological/neuropsychological-testing count against the outpatient benefit?

A. Yes, psychological/neuropsychological testing does count against the annual outpatient benefit. Preauthorization must be submitted for such testing by completing the Psychological Evaluation Review (PER) form, which can be found at www.ValueOptions.com.

Q. Can a Member be seen more than one (1) hour per day?

A. 1. For outpatient care, the member can have different services with different providers that may exceed one (1) hour in one day. For example, a member may have a therapy session (90806) with one provider and a medication evaluation (90862) with a different provider, both equaling 1.25 hours. This is acceptable. Members cannot have two (2) of the same services with the same provider on the same day. For example, a member cannot have an individual session in the a.m. and an individual session in the p.m. with the same provider. If a member is in crisis and the outpatient provider is spending more than

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one (1) hour with the member, the provider will only get paid for up to one (1) hour.

Q. Does ValueOptions, Inc. allow two 90801's at a facility?
Yes, please call our Customer Service number on the back of the member's identification card.

Q. If I render a 90804 (20-30 minute face-to-face session), how does this count toward the member's benefit plan? Do I get 2 for 1?
A. No. Each service code billed will count as one (1) session toward the member's benefit plan.