

MEDICAID/HMO

(Includes Child Health Plus and Family Health Plus)

PROVIDER CLAIMS BILLING INSTRUCTIONS



2005

Benefit Plans/Covered Services as of 1/1/05:

State sponsored plans have 3 products: Medicaid, Child Health Plus and Family Health Plus. Please see below for a more detailed outline of the benefits for the 3 products below:

Medicaid:

Inpatient Mental Health – no day limit
Inpatient Detoxification – no day limit
Inpatient Rehabilitation – no day limit
Outpatient Mental Health services – no visit limit

SSI:

Benefits: Unlimited inpatient and outpatient detox services
All other services such as inpatient/outpatient mental health and substance abuse rehabilitation are not authorized by ValueOptions and should be billed to the state directly on a fee for service basis.

Services NOT Covered by Managed Medicaid:

(Members are still eligible for these services but they should be billed directly to Medicaid and not to ValueOptions)

- Therapeutic Communities
- Residential Treatment Centers
- Partial Hospitalizations
- Day Treatment Programs
- Alcohol Day Facilities
- Article 16 Clinic Services (Developmental Disability and Mental Retardation)
- Severely emotionally disturbed children in treatment at designated S.E.D clinics
- Intensive Outpatient Treatment (IOP)
- SSI recipients (some exceptions - see above)
- As of 4/1/02: All substance abuse treatment except Detoxification, Ambulatory Detoxification and Inpatient Rehabilitation services are billable directly to fee-for-service Medicaid.

Child Health Plus (CHP):

Eligible Population: Children ages 19 and under. (For children who are NOT eligible for Medicaid)

Benefit year: Calendar year

Benefits: 30 days inpatient combined mental health and substance abuse
60 visits combined mental health and substance abuse
No co-payments
No alternative levels of care

Family Health Plus (FHP):

Eligible population: Adults ages 19-65 (For Adults who are not eligible for Medicaid)

Benefit year: Calendar year

Benefits: 30 inpatient combined mental health, substance abuse rehabilitation and Detox days
Unlimited inpatient detox days if care is rendered at any general hospital
60 outpatient visits, combined mental health and substance abuse
No co-payments

20 Visit Authorization Waiver for Medicaid

ValueOptions is also pleased to announce a change in our authorization process for all of our New York Medicaid business (**except Suffolk Health Plan and VidaCare**); and **excluding all GHI business (GHI-BMP, Family Health Plus and GHI Medicare Choice PPO)**. Our system has been programmed to pay for 20 Outpatient Mental Health and/or 20 Outpatient Chemical Dependency sessions per member without an authorization for in-network providers only. Visits are subject to benefit requirements. The visits are not CPT code specific and can be billed in any combination of mental health CPT codes.

Psychological/Neuro-Psychological testing:

If psychological testing is necessary:

- Advise the representative during the registration of the initial evaluation
- A psychological testing form will be mailed to you
- Please complete and return the form to us: ValueOptions, PO Box 1690, New York, NY 10116-1690
- ValueOptions will review for medical necessity and notify you of the determination.

Outpatient Mental Health Visits:

To request additional outpatient visits (beyond the initial 20 visit):

- An OTR (Outpatient Treatment Report) must be completed and submitted two (2) weeks prior to the last utilized visit. For a NYC Service Center OTR visit our website at www.valueoptions.com.
- Please send completed OTR's to ValueOptions, PO Box 1690 New York, NY 10116-1690

Interactive Voice Response:

IVR is an automated voice response system, which allows you to obtain information about member eligibility via the telephone 24 hours a day, seven days a week.

To use IVR, please call **(866) 752-5447**.

In order to access IVR, you will need:

- Your ValueOptions provider number for Medicaid members
- Member/subscriber's identification #
- Member's name
- Member's date of birth
- Start date of treatment
- Procedure codes requested

Billing Process:

Timeframe for Claims submission:

- Claims must be submitted to ValueOptions for payment no later than 180 days after the services were rendered

Claims submission:

- Electronic – You can now electronically submit claims to ValueOptions. For more information, Please call (888) 247-9311
- HCFA (CMS) 1500 for outpatient services
- UB92 for inpatient services

Paper claims – CMS (HCFA) 1500 must include all of the following elements:

- Patient/member HMO plan ID number (box 1a)
- Patient/member last name (box 2)
- Patient/member first name (box 2)
- Patient/member address (box 5)
- Patient's date of birth (box 3)
- Insured's name (box 4)
- Insured's address (box 7)
- Patient's relationship to the insured (box 6)
- Patient's signature authorizing the release of medical information (box 12)
- Patient's signature authorizing the payment to be sent to the provider (box 13)
- DSM diagnosis code (21a)
- CPT procedure codes (box 24d)
- Dates of service (box 24a)
- Number of visits (box 24g)
- Provider's charges (box 24f)
- Place of service (box 24b)
- Provider's federal tax identification number (box 25)
- Provider's acceptance of assignment of benefits (box 27)
- Provider's name and licensure, signature (box 31)
- Service location (box 32)
- Provider's billing address (box 33)

UB-92 must include all of the following elements:

- Facility name and address (box 1)
- Type of bill (box 4)
- Facility's federal tax identification number (box 5)
- Statement covers period – from and through (box 6)
- Patient's name (box 12)
- Patient's address (box 13)
- Patient's date of birth (box 14)
- Patient's sex (box 15)
- Marital status (box 16)
- Admission date (box 17)
- Admission Hour (box 18)
- Admission Type (box 19)
- Admission Source (box 20)
- Admission Hour (box 21)
- Patient's status (box 22)
- Responsible party name and address (box 38)
- Contracted revenue codes (box 42)
- Description (box 43)
- HCPCS/Rates (box 44)
- Service date (box 45)
- Service units (box 46)
- Total charges (box 47)
- Payer (box 50 a, b, c)
- Release of information certification indicator (box 52 a,b,c)
- Assignment of benefits (box 53 a,b,c)
- Prior payments (box 54)
- Insured's name (58 a, b, c)
- Patient's relationship to insured (box 59 a,b,c)
- Covered member's identification number (box 60 a,b,c)

- Group name (box 61 a,b,c)
- Principal diagnosis (box 67)
- Admitting diagnosis (box 76)
- Attending physician's identification number, name and licensure level (box 82)
- Provider representative (box 85)
- Date (box 86)

Entering Provider information:

Individual Provider Practice

When billing for outpatient mental health services, enter:

- the rendering provider's name in field #31
- provider tax identification number in field #25
- service address in field #33

Clinic/Facility Practice

When billing for outpatient mental health services rendered at a clinic, enter:

- the clinic tax identification number in field #25
- the clinic name and service address in field #33

Claims submission address:

New York Medicaid/HMO:

ValueOptions
240 Corporate Blvd
Norfolk, VA 23502

Suffolk Health Plan:

[Suffolk Health Plan Claims Department](#)
[P.O.Box 6007](#)
[Hauppauge, NY 11788](#)

Vida Care:

[Vida Care Claims Department](#)
P.O.Box 6022
Hauppauge, NY 11788

Deleted: Royal Health Care

“Clean Claims” Vs. “Non-Clean” claims:

A *clean claim* is a HCFA 1500 (outpatient) or UB92 (inpatient) that contains all required fields in which to process the claim.

A “non-clean claim” is:

- A HCFA 1500 or a UB92 that has invalid or missing information or ValueOptions is unable to confirm patient eligibility.
- If a patient/member is unable to be located by the identification number provided on a claim form, or they cannot be located by alphabetical search, the claim will be returned to the provider via a letter. The letter will advise the provider to verify the identification number given. Any changes should be made on a new claim and sent for consideration.

If additional information is required by ValueOptions, the participating provider agrees to cooperate with ValueOptions in providing any information reasonably requested in connection with claims for the purpose of reimbursement.

All bills by the participating provider will be considered final unless adjustments or an appeal request is received within sixty days from the date indicated on the explanation of payment statement sent by ValueOptions.

“Non-clean” claims will be returned to the provider due to invalid or incomplete information. All claims received with incomplete information will be returned with an Explanation of Payment statement advising the provider of the incorrect or invalid information. A corrected claim should be sent to ValueOptions providing the updated information for reconsideration. Please be sure to send all requested information timely.

IMPORTANT REMINDERS:

- Do not bill two different providers on the same HCFA form.
- In box 1 of the UB92 if you use a PO BOX for the address you must also provide a street address.
- ***For tips on completing UB92's, please refer to Attachment 1.***

Reimbursement:

- You will be reimbursed at the agreed upon schedule of allowance for covered services
- As per the terms of your provider contract with ValueOptions you are not permitted to balance bill members (i.e. members cannot be charged in excess of the contracted or negotiated rates).
- Providers may not bill members for services that are to be paid by ValueOptions or for failure to authorize, non-authorized services or claims denied for not meeting the timely filing guidelines.
- Billing for missed appointments is not allowed.
- Providers may submit for only one professional service per day except for the following:
 - Outpatient psychotherapy with a non-psychiatrist participating provider and medication management with a participating provider psychiatrist on the same day
 - Outpatient psychotherapy and psychological testing on the same day
 - When care has been deemed medically necessary by the Clinical staff and certification has been given for more than one service per day
- All reimbursements are based upon certification for services and the member's eligibility at the time the service is rendered.

Timely Filing and Claim Submission Guidelines:

- Timely filing is the practice of submitting a clean claim to ValueOptions within ninety days from the date on which services were provided.
- A separate claim form must be submitted for each patient for which the provider bills and it must contain all of the required data elements

Please limit each billing line to one date of service and one procedure code.

Do's and Don'ts for Paper Claim Submission

Please use the guidelines listed in the “Do” section below. Following the items in the “Don't” Section will cause your claim to deny.

Do's:

- Use black or blue ink
- Print claim data within the defined boxes on the claim form
- Use white correction tape or white-out for corrections
- Submit notes on 8 ½" x 11" paper
- Use an 8-digit date format (e.g., 10212000)
- Use the patient's date of birth

Don'ts:

- If you must hand print, use neat block letters that stay within field boundaries
- Do not use red ink unless for internal use only
- Do not use dashes or slashes in date fields
- Do not circle charge amounts
- Do not use fonts smaller than 8 point, 10 point is preferred
- Do not use rubber signature stamps
- Do not put notes anywhere on the claim form
- Do not use labels, stickers or stamps
- Do not apply a handwritten signature
- Do not use proportional fonts (Times New Roman is an example of a proportional font)
- Do not use mixed fonts on the same form
- Do not use italics or script fonts
- Do not submit more than six lines on the HCFA – 1500 claim form
- Do not print slashed zeros
- Do not use highlighters to highlight field information as this often causes the field data to turn back and become unreadable

ValueOptions Customer Service

- Dedicated claims representatives are available to you from 8:30a.m. to 5:00p.m, Monday through Friday at 800-922-3626.
- You can also contact our website at www.valueoptions.com for extensive information regarding claim submission, news, tools, guidelines and our complete provider handbook.
- Network providers must notify us when there is a change in demographic information. Changes can be made by calling our Network Operations department at **1-800-397-1630**. If you have further questions, our Provider Relations representatives are available to assist during normal business hours at **1-866-477-9741**.