The Valued Provider

In This Issue

Personal Note
Yanick Hazlewood, Vice President
National Provider Relations and Contracting

Articles

Navigating the Medical Necessity Review Process

Patient Safety Efforts

Study Suggests Physicians Who Communicate Poorly Receive More Complaints from Patients

Did You Know This About Utilization Management?

What's New?

ValueOptions® Is Going Green!

ValueOptions® Support of Evidence Based Practice

ValueSelect Designation Program

Get Paid Faster!

Claims Corner: Tips for faster reimbursements

Network-Specific Information

Contact Us

For more information about articles, visit our Web site at www.valueoptions.com/providers/ProNews.htm.

Navigating the Medical Necessity Review Process

ValueOptions® has a responsibility to its clients to ensure that the healthcare benefits they administer for them are appropriately used. In part, this is accomplished by adherence to our established clinical criteria for determining medical necessity. It is helpful for providers to become familiar with these criteria so we are all speaking the same "language" during the review process.

Defining Medical Necessity

ValueOptions® defines medically necessary services as those that are: expected to improve an individual's condition or level of functioning, individualized and consistent with the patient's symptoms, consistent with nationally accepted standard clinical evidence, and no more intensive or restrictive than necessary.

ValueOptions®' clinical criteria are intended for use as a guide by the care management staff in determining medical necessity as well as the appropriate level of care for members receiving mental health and/or substance abuse services. The criteria provide guidelines for the provision of clinically appropriate and cost-effective services that promote recovery from the symptoms and lead to stabilization at the highest possible level of functioning. Characteristics of the local delivery system, including availability of alternative levels of care are also considered. ValueOptions® has developed a core set of criteria for mental health services and has adopted the American Society of Addiction Medicine Patient Placement Criteria, Second Edition-Revised (ASAM PPC-2R). In addition to clinical criteria, ValueOptions® utilizes treatment guidelines to help guide appropriate and clinically effective care for a variety of complex psychiatric conditions. ValueOptions® generally adopts guidelines widely recognized in the professional literature, such as the American Psychiatric Associations' Practice Guideline for the Treatment of Patients with Eating Disorders (Third Edition). Clinical Care Managers and Peer Advisors may refer to these guidelines during the review process. Our criteria and copies of the guidelines are available at www.ValueOptions.com in the Provider Handbook section.

Obtaining Authorization

First level reviews for higher levels of care and complex outpatient reviews are generally conducted by Clinical Care Managers. Clinical Care Managers are licensed mental health professionals (e.g., LMSW, RN) with a minimum of three years' prior clinical experience in a mental health or substance abuse setting.

Precertification is required for all planned admissions to higher levels of

Continued on page 2

Provider Forum Information
Visit http://www.valueoptions.com/providers/Training.htm to view and register online for our provider forums.

ValueOptions®
Improving Behavior to Improve Health

Personal Note

by Yanick Hazlewood, *Vice President National Provider Relations and Contracting*

Dear Provider Community,

As always, it is a pleasure to reach out to each of you through *The Valued Provider*.

I want to thank each of you for reading our publication and hope you will continue to do so. On page 3, in our "What's New!" section, you will notice that ValueOptions is going Green! This is an effort to be more cost-effective and efficient, *The Valued Provider* will be available online only. Just go to www.valueoptions.com/providers/ProNews.htm to read the latest updates about ValueOptions® and clinical articles. You can also access archived versions of *The Valued Provider*.

While online, don't forget to take advantage of the many other tools and resources available to you. Log in to ProviderConnect and submit/review claims, authorizations, or changes to your practice profile. Visit our Education Center to register for upcoming events or access PowerPoint presentations and handouts to events that you were not able to attend. Also, review the 2007 Handbook or download or print a copy for your files. There is so much to do while online with ValueOptions.

Be sure to read this issue in its entirety to learn about electronic funds transfer Updated Clinical Forms on-line (page 3), network-specific information (beginning on page 4), and so much more!

Navigating the Medical Necessity Review Process (con't)

care (e.g., Inpatient Substance Abuse Rehabilitation, Residential Treatment, Partial Hospital Programs). For urgent inpatient admissions, providers are expected to ensure the safety of members and request certification of emergency care within 24 hours of an admission to an inpatient unit. Some benefit plans allow a designated number of outpatient "pass-through" sessions that do not require authorization. However, all outpatient visits beyond these "pass through" sessions require prior authorization.

If continued treatment is needed beyond the initial certification period, the provider must submit additional information to ValueOptions® to request additional days/visits. It is important that this review process be completed prior to the end of the current certification period. Continued treatment is medically necessary as long as the treatment remains clinically appropriate and potentially effective. Other factors considered include: coordination with other relevant providers, patient participation, progress in relation to symptoms or impairments, family involvement (when indicated), the presence of active treatment with measurable goals, and discharge planning.

Clinical Care Managers cannot deny a request for services. Requests that do not appear to meet medical necessity criteria are referred to a Peer Advisor for second level or peer-to-peer review. ValueOptions®' Peer Advisors are experienced, psychiatrists and clinical psychologists who remain active in private practice. The majority of psychiatrist peer advisors are board certified in their specialty areas. Licensed Clinical Psychologists provide peer reviews for psychological testing and outpatient treatment. Written notification of an adverse determination is issued to the patient, practitioner and facility within decision timeframes. The written notification will include important information about the right to and instructions for initiating an appeal, as well as the timeframe for requesting an appeal.

As a frame of reference, in 2006, approximately 94% of care requests received by a large commercial client were approved at the first level review. Of the requests referred for second level review, approximately 87% were either approved in full or partially approved with some modification of the request.

If you are scheduled for a telephonic second level/peer-to-peer review, be prepared to provide clinical information that justifies the requested treatment services. Be organized, brief, and give only pertinent history. In order to make the process go more smoothly and quickly, we suggest that you have the medical record with you and be prepared to discuss the following: current DSM-IV TR diagnoses, current symptoms and impairments, current treatment plan including measurable goals, progress made toward the goals, what goals will need to be attained prior to discharge, and how many additional days/visit you anticipate will be required.

If there is insufficient information to make a medical necessity determination, the Clinical Care Manager or Peer Advisor may invoke a lack of information process. In this instance, the provider will be notified of the information needed and the timeframe to furnish the necessary information. Once the information is received, or the time period for furnishing the information has expired, the decision will be issued.

What's New?

ValueOptions® is Going Green!

The Valued Provider will now only be available online at http://www.valueoptions.com/providers/ProNews.htm. It is a small effort to represent the ultimate long-term investment in our health and the health and well being of generations to follow. We hope you visit us online and continue to enjoy the provider updates, ValueOptions®' Top 10, clinical articles, and network-specific information. We will send you correspondence letting you know when future newsletters will be available online. If you do not have internet access and would like a hard copy of The Valued Provider please contact ValueOptions® at (800) 397-1630 and we will distribute a copy to you.

ValueOptions® Support of Evidence-Based Practices

ValueOptions® supports providers in their use of proven therapeutic approaches in their treatment of our members. We have begun the work of reviewing the research evidence for specific therapies and offer information for providers about Evidence Based Practices. This information is located in a summary table on the Provider web site under Education then Provider Tools. ValueOptions® will expand this summary table over time and continue to offer this information as a service to our providers.

ValueSelect℠ Designation Program

ValueOptions® is pleased to announce the implementation of a new program, the ValueSelect℠ Designation Program. This program is offered to providers who use proven treatment techniques in their practice, and complete pre- and post-treatment assessments on their patients. Additionally, providers commit to promote member treatment surveys and administer at least 85 percent of their transactions online using ValueOptions® web-based technology. In an effort to encourage advanced training, ValueOptions® recently partnered with Behavioral Tech, LLC, a nationally renowned evidenced-based practice (EBP) training program that is currently extending a 10% discount to ValueOptions® & ValueSelect℠ providers for upcoming trainings. Visit their web site - http://www.behavioraltech.com for more information. To register with Behavioral Tech, LLC,, please call (206) 675-8588 and inform them that you are a ValueOptions® & ValueSelect℠ provider and give them the promotional code: "*valueopts2007*" to receive the discount!

In recent months ValueOptions® has added CEAP providers to the ValueSelect℠ Designation Program. This designation is offered to CEAP providers who meet the thresholds for EAP provider quality profile tools.

In the coming months, selected providers will receive more detailed information about these exciting opportunities. Please stay tuned for more training discount updates!

Updated Versions of the Outpatient Forms Now On-line!

ValueOptions® would like to let Providers know the following forms have been updated and can be found at http://www.valueoptions.com/providers/Clinforms.htm.

If you are a registered ProviderConnect user the updated forms are already reflected in the system

It's That Time of Year of Again! Questions about your 1099?

Below is the number for providers to call for all questions regarding their 1099.

703-390-4936

Claims Corner:

Tips for faster reimbursements!

When submitting electronic claims (EDI or single claims submissions) please remember to add the consumer's 10-digit Medicaid number in the Patient ID/Member ID field. And if you file paper claims: CMS-1500 (Box 1A0, UB-04 (Box 60).

Including this number will help speed up the claims process - and you paid faster!

AchieveSolutions: Your own behavioral health resource center

Looking for behavioral health resources and tools that you can share with your patients? Look no further – we've got a solution! As a ValueOptions New Mexico provider, you have access to our award-winning Web site, AchieveSolutions, which contains hundreds of regularly updated articles on current behavioral health topics. The Web site also features assessment tools and links to valuable resources – all designed to help your patients better understand their behavioral health diagnosis and manage life's stressors.

"Each section of the site I visited was practical and succinct and offered options for further exploration through recommended books or Web sites. The topics addressed a wide range of issues and needs in a format that felt very user-friendly and integrated. I really like using this site!"

Accessing AchieveSolutions is easy. Just log on to www.valueoptions.com and select the "Provider" portal. Select "Education Center" from the left menu and click on "AchieveSolutions."

When Checking Eligibility in ProviderConnect ...

The date field is what triggers the results viewed. For accurate information, enter the date of service you want to verify in the "As of Date" block displayed on the Eligibility & Benefits Search screen pictured below.

ValueOptions Online Services - Providers - Members - Microsoft Internet Explorer

https://www.valueoptions.com/pc/eProvider/providerMember.do

ValueOptions Home | Provider Home | Contact Us | Log Out

PROVIDERCONNECT ValueOptions

Home
EDI Homepage
Specific Member Search
Authorization Listing
Claim Listing and Submission
My Online Profile
My Practice Information
Provider Data Sheet
Compliance
Handbooks
Forms
Network Specific Information
Education Center
Contact Us

Eligibility & Benefits Search

Required fields are denoted by an asterisk (*) adjacent to the label.

Verify a patient's eligibility and benefits information by entering search criteria below.

*Member ID (No spaces or dashes)
Last Name
First Name
*Date of Birth (MMDDYYYY)
As of Date 05242006 (MMDDYYYY)
Search

© 2005 ValueOptions

Return to ValueOptions Home | Return to Provider Home | Contact Us | Privacy Statement | Terms and Conditions

Did You Know This About Utilization Management?

ValueOptions® in no way gives rewards or incentives, either financially or otherwise, to its network providers and practitioners, Clinical Care Managers and Physician Peer Advisors, or other individuals involved in conducting utilization review, for issuing denials of coverage of service or inappropriately restricting care. All utilization related decisions are based upon the clinical needs of members, benefit availability and appropriateness of care.

VALUEOPTIONS®
Improving Behavior to Improve Health

Study suggests that physicians who communicate poorly receive more complaints from patients.

MedPageToday (9/5, Osterweil) reports, "Doctors who scored poorly on the patient-physician communications portion of a clinical skills examination were significantly more likely to be the targets of patient complaints to medical authorities than fair or good communicators," according to a study published in today's issue of the Journal of the American Medical Association. Robyn Tamblyn, Ph.D., of McGill University, and colleagues, "conducted a cohort study of all 3,424 physicians who took the Medical Council of Canada clinical skills examination between 1993 and 1996 and who were licensed to practice in the provinces of Ontario and Quebec." The researchers followed these physicians until 2005. There were 1116 complaints filed against the participants. The authors determined that 696 complaints had "some merit." They found that "17.1% of the physicians had at least one complaint, and 81.9% of the complaints were about communication problems or quality-of-care issues." Based on communications scores which "ranged from a low of 31 to a high of 723," the researchers found that "every two standard-deviation decrease in communication scores was associated with 1.17 additional retained complaints per 100 physicians per year, translating into a relative risk of 1.38 (95% confidence interval, 1.18 to 1.61). "The Valued Provider will now only be available online at http://www.valueoptions.com/providers/ProNews.htm. It is a small effort to represent the ultimate long-term investment in our health and the health and well being of generations to follow. We hope you visit us online and continue to enjoy the provider updates, ValueOptions®' Top 10, clinical articles, and network-specific information. We will send you correspondence letting you know when future newsletters will be available online. If you do not have internet access and would like a hard copy of The Valued Provider please contact ValueOptions® at (800) 397-1630 and we will distribute a copy to you.

Get Paid Faster!

In the coming months ValueOptions® will offer providers that currently submit claims through our Electronic Data Interchange (EDI) system a new product called PaySpan Health. PaySpan will offer many advantages over our current EDI software. ValueOptions is inviting providers to take advantage of free Electronic Transfer of Funds (EFT) by registering with PaySpan Health. This service will allow for convenient payments directly to a bank account too waiting for paper checks or paper vouchers to be printed and delivered, improved cashflow through automated payments, on-line access to view remittance records at your convenience, on-line reporting tools to increase access to adjudicated claims information , and ability to export data into your Practice Management or Patient Account System.

This product will be FREE to providers! ValueOptions will provide you with more information on how to take advantage of this new and exciting opportunity in the coming months Stay Tuned!

Navigating the Medical Necessity Review Process (con't)

Appeal Process

If your treatment request is modified or denied, review the decision with your patient and discuss whether they wish to appeal the decision. Learn and follow the sequence of appeals the managed care company offers. These may vary per patient based on benefit plan requirements and state regulations. ValueOptions' standard appeal process offers two levels of internal appeal, unless otherwise stipulated by contract or regulatory requirements. The first level of appeal is typically another telephonic peer-to-peer review, with a different peer advisor than the one who rendered the initial denial. The second level of appeal may be another telephonic peer-to-peer review or review of the treatment record by a committee. Providers are requested to submit any information that supports the need for the requested treatment. You may want to submit an appeal letter along with this documentation. Keep letters brief and to the point. You may want to reference specifics from the managed care company's medical necessity criteria. Appeals are not a waste of time as up to 50% of denials are reversed in full or modified with some additional days/visits authorized.

continued on page 6

Great Lakes Service Center (GLSC)

New Office Location for ValueOptions GLSC

Effective June 25, 2007, the Great Lakes Service Center's new address is 48561 Alpha Drive, Suite #150, Wixom, MI 48393.

The toll-free numbers for members and providers will remain the same. New claims information is listed below. Please update your files with this important information.

New Mailing Address for Claims:
(Select the address as appropriate)

BCN Claims:
ValueOptions, Inc., PO Box 930829
Wixom, MI 48393-0829

Non-BCN Claims:
ValueOptions, Inc. PO Box 930321
Wixom, MI 48393-0321

New FAX# for ORF Forms:
(248) 697-0908

The move allows the GLSC to create from the ground up a service call center with all of its operations on a single floor and, thereby, help them maintain and improve operational efficiencies in the delivery of services to members and providers.

As part of the move, ValueOptions staff received new phone numbers and extensions.

If you have any additional questions regarding ValueOptions Great Lakes Service Center's move to its new location in Wixom, Mich., please feel free to contact Provider Relations at (800) 247-6070.

Patient Safety Efforts

The Institute of Medicine's landmark report "To Err is Human: Building a Safer Health System" (1999) followed by "Crossing the Quality Chasm" (2001) were reports that publicly highlighted medical errors. The reports included experts' estimate that as many as 98,000 people die in any given year from medical errors that occur in hospitals. Preventable medical errors are the leading causes of patient injury and death throughout the country.

In an effort to evaluate and encourage network-wide patient safety practices ValueOptions® surveyed Great Lakes providers' during the last quarter of 2007. The survey was sent to providers of inpatient, partial and residential levels of care. Several of the patient safety survey questions were adapted from the Joint Commission on the Accreditation of Healthcare Organizations' 2007 Behavioral Healthcare National Patient Safety Goals. Question categories related to discharge planning; medication management; coordination of care and organizational policies and procedures.

To date we have received responses from approximately 40% of the providers surveyed. We are excited about the excellent response rate and thank all providers who have responded! Aggregate results from the survey will be posted on the ValueOptions® website during the first quarter of 2008. Please be sure to visit the ValueOptions® website for the patient safety results.

Stay Connected...

Do we have your most recent email, fax, phone and mailing address? Please help us keep you and your staff informed about the lates reimbursement news, system changes, and new initiatives by updating your contact information on ProviderConnect at www.valueoptions.com/pc/eProvider/providerLogin.do. Or you can always call ValueOptions at (800) 397-1630 with any questions and we will be happy to assist you.

Northeast Service Center (NESC)

Attention MIT Providers!

For members with dates of service after 12/31/07, please call 617-253-5979.

Empire Plan

Understanding your Empire Plan Explanation of Benefits:

To ensure that NYS Empire Plan providers are receiving their claims payments promptly, ValueOptions has compiled a list of the most common reasons a claim is denied and how to avoid a denial in the future. Providers can avoid future denials by utilizing this list, which details the most common messages providers receive with a denial. Please review this guide on-line prior to submitting your next set of claims. Providers should see a reduced number of denied claims and turnaround time in claims payments.

The guide: "Understanding your Empire Plan Explanation of Benefits", can be found and downloaded at www.valueoptions.com (click on Network-Specific" and then "Empire Plan).

Generally, when a claim is submitted with inaccurate or incomplete information, a claims adjustment has to be performed. Each time a claim is adjusted, several additional steps are required which can include: additional research, reworking of the claim and requesting additional documentation from the provider. All of these steps can cause a potential delay in paying the claim. Help us process your claim more quickly by submitting complete and accurate claims!

New Enhancements to the Authorization Process

ValueOptions' NYS Empire Plan is excited to announce two new enhancements to the authorization process. Providers can request outpatient authorizations online by logging in to ProviderConnect at www.valueoptions.com. As an alternative, providers can also submit an Outpatient Request Form as well as Medication Management and Psychological Testing request forms by fax to (518) 270-2033 or (866) 757-5101.

You are only required to submit request forms after the initial ten outpatient mental health "pass-through visits," which are available per member, per provider, per lifetime. Prior authorization is still required for psychological testing.

If you have any questions, contact provider relations at (800) 235-3149.

Timothy's Law

On December 22, 2006, legislation known as "Timothy's Law" was signed. This law, which sets a minimum level of benefits for mental health, became effective January 1, 2007. As a result of this legislation, several of our Empire Plan members received a reduction in copay. Below is an outline of the copay changes identified:

- Copay code B: In-network office visit copays were reduced from $15 to $12.
- Copay code X: In-network office visit copays were reduced from $15 to $10.

Should you have any questions, please call the Empire Provider Line at (800) 235 – 3149.

NOTE: Copay Codes are indicated on the front of the Empire Plan Identification card (above)

Navigating the Medical Necessity Review Process (con't.)

Some plans and states also allow for an independent external review. For example, residents of New York State have the right to request an external appeal after an adverse determination that is upheld at the first level of appeal. This appeal is requested through the Department of Insurance and is conducted by reviewers who are not affiliated with the managed care company. There may be a cost to the patient to request an external appeal.

Provider Responsibilities

In order for patients to receive the highest quality of services, it is important for providers and managed care companies to work in partnership and maintain a cooperative relationship. Members should be excluded from any disputes between the provider and managed care company. Some key things to remember in order to avoid unnecessary clinical or administrative denials are:

- Verify member eligibility and benefits prior to rendering services.
- Preauthorize care when required.
- Submit claims within timely filing requirements, normally within 90 days of rendering services.

As a participating provider with ValueOptions, it is important for you to review and understand ValueOptions' Provider Handbook. Two key sections are the "Participating Provider Responsibilities" and "Utilization Management." One responsibility relates to coordination of care. Providers are strongly encouraged to identify any other behavioral health providers, as well as all physical care providers, involved in the health care of their patients and to obtain member consent to inform and coordinate the delivery of care with these providers.

Another important participating provider responsibility and expectation of all managed care companies is that providers develop individualized treatment plans with specific measurable goals and objectives. Patients should be actively involved in the treatment planning process.

Lastly, it is important that providers understand when and if they can bill patients for services for which the provider does not receive reimbursement from ValueOptions. Providers may not bill patients for services that were denied by ValueOptions for administrative reasons (i.e., the provider's failure to comply with their participating provider responsibilities, including all requirements for requesting certification). Providers may bill patients if the member has met their benefits maximum.

Providers should always discuss any clinical denials based on medical necessity with the patient. At the time of the initial denial, the provider must inform the patient of the denial and may obtain their written consent to be financially responsible for the denied services if not overturned at appeal. The provider must complete all levels of ValueOptions' appeals available before billing the member directly for any denied services.

The medical necessity review process can be confusing. Becoming a healthcare provider who better understands it will benefit you and your patients.

Author:
Donna Hakala, RN, MS

Ms. Hakala has 12 years of experience in managed behavioral health care and currently serves as the Director of Clinical Operations for the Empire Plan Service Center of ValueOptions in Troy, NY. She is a master's prepared Registered Professional Nurse with over 20 years of clinical experience in a variety of behavioral health care settings.

Important Information Regarding Screen Actors Guild - Producers Health Plan Mental Health and Substance Abuse Benefits

Effective January 1, 2008, the mental health and substance abuse benefits for the participants in the Screen Actors Guild - Producers Health Plan will have several modifications. These changes double the number of days available under alternative levels of care for mental health inpatient benefits, eliminate the 50% reduction penalty for not completing a chemical dependency program, and increase the dollar amount of coverage for the detoxification benefit to $2,000 per year. A $250 annual deductible will also be added to the inpatient/alternative level of care mental health benefit. The Plan I inpatient mental health annual maximum will reduce to 45 days while there is no change to the Plan II inpatient mental health annual maximum. The outpatient mental health benefits in both plans remain the same.

For more detailed information about these benefit changes, please call: Claims Customer Service and Pre-certification toll free number 1-866-277-5383.

Interested in electronic claim submission? Contact our ValueOptions Electronic Claims Specialist at 888-247-9311 or visit our website at www.valueoptions.com for more details.

Online provider services:

Now Available! Use ProviderConnect to request inpatient and outpatient authorizations online, update your provider profile, review and submit claims, and so much more. Visit http://www.valueoptions.com/providers/Providers.htm and login to or register for ProviderConnect.