



WELCOME

ValueOptions Provider Form
Newark, NJ
June 15, 2005





Provider Relations



Overview – ValueOptions, Inc.

- ValueOptions was formed in 1998, when FHC Health Systems, parent company of OPTIONS Health Care acquired Value Behavioral Health, Inc. (VBH). The new company, *ValueOptions, Inc.*, became the second largest managed behavioral health care company in the nation.
- Provide managed Mental Health and Substance Abuse Programs, Workplace Services, Employee Assistance Programs, Psychiatric Disability Management, Medicaid Behavioral Health Management, and Child Welfare Programs for more than 24 million lives.
- 2004 Annual Provider Satisfaction Survey - independent auditor
 - 91% overall satisfaction
 - 96% availability across all licensure types

Information and Inquiries

If you have a question about authorizations or benefits:	Call the 800 number on the Member's insurance card.
If you have questions about clinical criteria or other aspects of the Provider Handbook or need specific forms:	go to www.ValueOptions.com
If you have changes regarding provider demographics (address/telephone # changes), adding/deleting practice addresses, etc.:	submit changes in writing. Forms can be found at www.ValueOptions.com .
If you have questions/concerns about credentialing, network status, or claims:	call 1-866-858-9033 and select the correct prompt.
If you have a technical question about Electronic Data Interchange (EDI), our Electronic Claims software:	contact the EDI Help Desk at 1-888-247-9311.

Participating Provider Responsibilities

- Partnership with *ValueOptions* to deliver quality services to Covered Members.
- Reporting and communication:
 1. Changes in address, Tax ID, name, network status, accessibility, service issues, hours of operation.
 2. Adverse incidents (within 24 hours).
 3. Claim, suit, criminal or administrative proceeding against provider which materially affects compliance with community standards and applicable laws.
 4. Expiration of required professional liability insurance.
- Confidentiality: Compliance with all State and Federal laws/regulations with respect to Member information and records

Participating Provider Responsibilities *(cont.)*

- Coordination of care: Coordinate delivery of care with all providers involved in Member's health care.
- Allow Treatment Record Reviews and Site Visits.
- No Balance Billing.

Exceptions are: Charges for missed appointments and charges for services not covered under the Member's Benefit Plan. Charges for non-certified treatment can only be billed to the member after appeals are completed. A signed member's consent must be dated at the time that non-certified treatment begins. A general consent signed before treatment begins is not sufficient. Always contact the number on the back of the member's card to check Account Specific information.

Participating Provider Responsibilities *(cont.)*

- Maintain Treatment Record Standards -- compliance with policies and procedures of *ValueOptions* and accrediting body
- Obligation to Report/Duty to Warn
- Cooperation with ValueOptions Credentialing and Recredentialing Standards

ValueOptions' Website

Corporate Website



Corporate Provider Relations Website

The screenshot shows a Microsoft Internet Explorer browser window displaying the ValueOptions Corporate Provider Relations Website. The browser's address bar shows the URL: http://valueoptionsdev/wss/pvd_ols_home.html. The website features the ValueOptions logo at the top left, followed by navigation tabs for About, Services, News, and Careers. Below these are links for Overview, History, Family, Leadership, and Contacts. A search bar is located in the top right corner. The main content area is divided into two columns. The left column contains a large blue box with the word "Provider" and "Online Services" below it, and a "For Providers" section with a list of links: Handbooks, Forms, Contract-Specific Information, Online Services, News, Education, Contacts, New Provider Application, and Provider Profile Lookup. The right column features an "Online Services" section with buttons for Log In, Register, and Tour. Below this is a paragraph describing the eProvider service, followed by another paragraph explaining the benefits of eProvider, and a final paragraph detailing the security of eProvider transactions. At the bottom of the page, there are links for Home, Contacts, Site Map, Privacy Statement, and Terms and Conditions. The browser's status bar at the bottom indicates "Local intranet".

ValueOptions
About Services News Careers
Overview History Family Leadership Contacts

Search Links >>

Provider
Online Services

Online Services

- Log In
- Register
- Tour

ValueOptions' eProvider is our Web-based provider information and claims tracking service. Accessible 24x7, eProvider is available to providers as part of our overall effort to improve communication, provide useful, timely information and foster more rapid claims payment through e-commerce.

In fact, eProvider provides quicker adjudication, information regarding claims status, nearly instant member eligibility status and more! If you'd like to log-in to eProvider, register for access, or simply take a quick tour of eProvider's capabilities, just click the buttons to the right! Or, visit our [provider handbook](#) if you would like to learn about our online services in detail.

To access eProvider, all you need is a username and password (the same username and password you have been using to submit claims via the bulletin board service). Once you are in, you can perform a host of potentially time consuming tasks with the touch of a few keystrokes.

All eProvider transactions are completed in a secure manner. We are VeriSign <http://www.verisign.com/> certified and all patient and claims information remains confidential. If you have questions about security or another issue, please call eSupport Services at 888-247-9311 or email us at e-supportservices@valueoptions.com.

Home | Contacts | Site Map | Privacy Statement | Terms and Conditions

Local intranet

Corporate Provider Relations Website

- **Company News:** Read the most recent news about our company.
- **Network-Specific Information:** Find handbooks, forms, and other details that pertain to program-specific networks.
- **Educational Opportunities:** View educational articles and 2005 Provider Forums. eLearning under development.
- ***The Valued Provider:*** Access articles found in our provider newsletter. Read informative articles and learn about new initiatives underway at *ValueOptions*.
- **Change of Address and W-9 forms:** Help us keep the information we have on file for you current by downloading, completing and sending these forms to us.
- **Online Services:** ProviderConnect - confirm eligibility of our members for service, submit claims directly over the internet, and check the status of a claim you submitted (etc.).
- **Forms:** Current VO forms posted for your convenience to download and submit.
- **Provider Handbook:** Available online. Always up-to-date.

Provider Handbook

- Prepared as a guide to *ValueOptions*' policies and procedures for individual providers, affiliates, group practices, programs and facilities.
- Provides important information regarding the managed care features incorporated in the *ValueOptions*' provider contract; and also reflects the policies that are applicable to our "general" commercial product lines.
- Divided into the following sections:
 - **Administration**
Provider Responsibilities, Credentialing and Sanctions, Claims, Online Services, Referral, Quality Management, and Utilization
 - **Clinical Criteria**
 - **EAP Information**
 - **Treatment Guidelines**
 - **Forms**
 - **Glossary of Terms**
- We also made each section printer friendly for your convenience.

Corporate Member Website

The screenshot shows a Microsoft Internet Explorer browser window displaying the ValueOptions Corporate Member Website. The address bar shows the URL: http://valueoptionsdev/wss/mbr_home_out.html. The browser's menu bar includes File, Edit, View, Favorites, Tools, and Help. The toolbar contains icons for Back, Forward, Stop, Home, Search, Favorites, Media, and other standard browser functions. The website content includes a red-bordered notice at the top: "Please Note: this page is a replica of the VO.com external page. Some external links may not work properly." Below this is a search bar with a "GO" button. The ValueOptions logo is prominently displayed on the left, with a navigation menu containing "About", "Services", "News", and "Careers". A central section titled "Member Online Services" features a "Member Online Services" graphic with the word "Member" in a large font and "Online Services" below it. To the right of this graphic are "Log In" and "Register" buttons. Below the graphic is a "For Members" section with a list of links: Member Home, Resource Center, Education Center, Achieve Solutions, Contacts, Find a Provider, and New Member Registration. The "Member Online Services" section contains a welcome message and a list of links: Resource Center, Education Center, Achieve Solutions, and Contacts. At the bottom of the page, there is a footer with links: Home | Contacts | Site Map | Privacy Statement | Terms and Conditions. The browser's status bar at the bottom right shows "Local intranet".

Please Note: this page is a replica of the VO.com external page. Some external links may not work properly.

Search

ValueOptions About Services News Careers

Member
Online Services

Member Online Services

Welcome to ValueOptions' Member Online Services! In this section, you will find materials that can help you in a variety of ways. If you are interested in downloading forms or manuals, if you would like to read up on facts about specific behavioral health conditions, or if you simply want to login to the Achieve Solutions website, just click on the links below.

- > Resource Center
- > Education Center
- > Achieve Solutions
- > Contacts

For Members

- Member Home
- Resource Center
- Education Center
- Achieve Solutions
- Contacts
- Find a Provider
- New Member Registration

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Local intranet

Corporate Member Website

- **Resource Center**
 - Print Members Rights and Responsibilities poster
 - Post in your office14 - visible to all members
- **Education Center**
 - Offers information on various Mental Health topics

Technology Enhancements

Increased convenience & decreased administrative burden

- TeleConnect (Interactive Voice Response) – May 2005
 - Voice recognition software that will allow for eligibility verification, claims status, benefits, form requests and outpatient authorizations*
- ProviderConnect (Provider Online Services) – July 2005
 - Enhanced online claims submission, claims status, benefits, eligibility verification, form request and Web-based outpatient authorizations*

* Outpatient Authorizations via TeleConnect & ProviderConnect will be introduced beginning in Q4'05.

TeleConnect (Interactive Voice Response)

- Replacing our existing touch tone telephonic systems.
- Offers easy-to-navigate voice or touch tone self-service.
- The new system will give you 24/7 access to conduct authorization approvals, claims inquiries, eligibility and benefit inquiries - that is, the ability to retrieve information at your convenience.
- Outpatient authorizations can be completed via TeleConnect in 4th Quarter 2005.



What is TeleConnect?



TeleConnect is an interactive voice-response system that allows members and providers to:

- Access benefits
- Determine eligibility
- Review claims
- Request forms

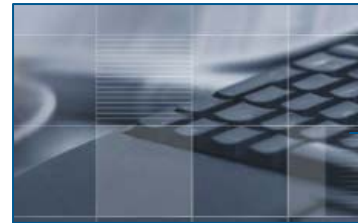
In the future, TeleConnect will also allow providers to register outpatient care.

The Difference



Current System

- Touch tone only



TeleConnect

- Touch tone or voice activation -- whichever the caller prefers
- More features

It's simple: When callers talk to TeleConnect, it talks back!

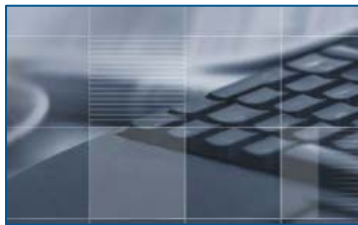
How TeleConnect Works

Call Routing



Callers select a menu option using their telephone keypads. Based on their selection, the call is routed to:

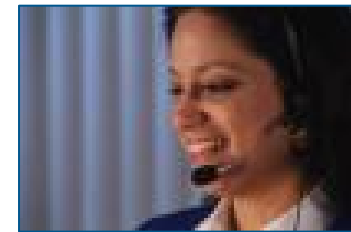
TeleConnect



All menu selections
except "other"

OR

Agent or Clinician



If "other" is
selected

ProviderConnect *(Provider Online Service)*

- Provides an online alternative to the telephonic services of TeleConnect.
- Gives providers a 24/7 available, easy-to-use tool for completing everyday service requests.
- Will allow users to check eligibility, benefits, claims status, claims history, claims payment and view correspondence on-line, outpatient authorizations (Fall 2005).
- Allows single and batch claims submissions
- Enable providers to view their demographic information and submit changes online.

In the Spotlight

**A Workplace Strategy for
Suicide Prevention**
Reaching Out to Troubled
Employees



for providers

for members

for clients

Recent News

ValueOptions Offers College
Students Improved Quality of Life

Schneider National Selects
ValueOptions' EAP Services

ValueOptions' Achieve Solutions
Web Site Wins eHealthcare
Leadership Award

Founded in 1983, ValueOptions develops and implements managed behavioral health and Employee Assistance Program services for Fortune 500 companies, national and regional health plans, as well as federal, state and local governments. Devoted to excellence in clinical care and customer service, we rank the well-being of our 23 million members as our first and foremost priority.

Over the last several decades, experience has taught us that when it comes to managing behavioral health care, solutions must be dynamic and diverse. To this end, ValueOptions understands that across all aspects of our daily business; vision, innovation, and operational expertise are the keys to success. By offering cutting-edge services for our clients, members, and providers, ValueOptions prides itself on consistently exceeding the evolving needs of the marketplace.



For Providers

- [Handbooks](#)
- [Forms](#)
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Online Services

-
-
-

ValueOptions' eProvider is our Web-based provider information and claims tracking service. Accessible 24x7, eProvider is available to providers as part of our overall effort to improve communication, provide useful, timely information and foster more rapid claims payment through e-commerce.

In fact, eProvider provides quicker adjudication, information regarding claims status, nearly instant member eligibility status and more! If you'd like to log-in to eProvider, register for access, or simply take a quick tour of eProvider's capabilities, just click the buttons to the right! Or, visit our [provider handbook](#) if you would like to learn about our online services in detail.

To access eProvider, all you need is a username and password (the same username and password you have been using to submit claims via the bulletin board service). Once you are in, you can perform a host of potentially time consuming tasks with the touch of a few keystrokes.

All eProvider transactions are completed in a secure manner. We are VeriSign <http://www.verisign.com/> certified and all patient and claims information remains confidential. If you have questions about security or another issue, please call eSupport Services at 888-247-9311 or email us at e-supportservices@valueoptions.com.

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Please Log In

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

Please log on using the form provided below.

*User ID

If you do not remember your user ID, please contact our E-Support HelpDesk.

*Password [Forgot Your Password?](#)

Log In

New User?

Please register for access.

Sign Up

The information and resources provided through the ValueOptions site are provided for informational purposes only. Behavioral health providers utilizing the ValueOptions site ("Providers") are solely responsible for determining the appropriateness and manner of utilizing ValueOptions information and resources in providing services to their patients. No information or resource provided through the ValueOptions site is intended to substitute for the professional judgment of a behavioral health professional. Providers are solely responsible for determining whether use of a resource provided through ValueOptions is consistent with their scope of licensure under applicable laws and ethical standards.



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Welcome Dr. Smith

WHAT DO YOU WANT TO DO TODAY?

- ▶ [Lookup a Member](#)
- ▶ [Review Claims](#)
- ▶ [Enter a Claim](#)
- ▶ [Submit a Batch Claims File](#)
- ▶ [Review an Authorization](#)

NEWS & ALERTS

- ▶ **Information Alerts to SWPA EDI Providers**
(5/18/2004 06:25 PM)
When billing VBH-PA as secondary payer... more
- ▶ **Important Notice Regarding Remittance Advices and Revenue Codes** (05/22/2004 06:52 PM)
Please be advised, HIPAA requires that all legacy three digit revenue codes be... more
- ▶ **Information Alert to All ValueOptions Submitters**
(05/19/2004 04:24 PM)
ValueOptions ETS and Online Services will be unavailable ...more

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■ **Member Eligibility & Benefits**

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Eligibility & Benefits Inquiry

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

Verify a patients eligibility and benefits information by entering your criteria below.

*ID Number *(No spaces or dashes)*

Last Name

First Name

Date of Birth *(MM/DD/YYYY)*

As-of Date *(MM/DD/YYYY)*



Demographics Enrollment History COB Benefits

Member eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Member

Member Number	1234567890
Alternate Number	
Member Name	Burgundy, Robert
Date of Birth	01/02/1953
Address	2345 Sunshine Drive, Anytown, MD 12345-6789
Alternate Address	2345 Sunshine Drive, Anytown, MD 12345-6789
Marital Status	M
Home Phone	(123) 456-7890
Work Phone	(123) 456-7890
Relationship	Self
Gender	M
Race	W

Eligibility

Effective Date	01/02/2003
Expiration Date	01/03/2005
COB Effective Date ?	01/02/2003

Subscriber

Subscriber Number	1234567890
Subscriber Name	Burgundy, Robert
Date of Birth	03/31/1968
Gender	M

Send Inquiry

Member's Authorizations

Member's Claims

Enter Claim

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Member eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Client ID: ABCDEFG
Client Name: ABC Company
Benefit Package#: 56445

■ Maximums and Limits

	In-Network	Out-of-Network
Annual Visit Limit (Inpatient Mental Health)	##	##
Annual Visit Limit (Inpatient Substance Abuse)	##	##
Lifetime Visit Limit (Inpatient Mental Health)	##	##
Lifetime Visit Limit (Inpatient Substance Abuse)	##	##
Out-of-Pocket Individual (Inpatient Mental Health)	##	##
Out-of-Pocket Individual (Inpatient Substance Abuse)	##	##
Out-of-Pocket Family (Inpatient Mental Health)	##	##
Out-of-Pocket Family (Inpatient Substance Abuse)	##	##
Annual Visit Limit (Outpatient Mental Health)	##	##
Annual Visit Limit (Outpatient Substance Abuse)	##	##
Lifetime Visit Limit (Outpatient Mental Health)	##	##
Lifetime Visit Limit (Outpatient Substance Abuse)	##	##
Out-of-Pocket Individual (Outpatient Mental Health)	##	##
Out-of-Pocket Individual (Outpatient Substance Abuse)	##	##
Out-of-Pocket Family (Outpatient Mental Health)	##	##
Out-of-Pocket Family (Outpatient Substance Abuse)	##	##

■ Inpatient

Deductible Amounts	In-Network	Out-of-Network
	\$25/Individual	\$25/Individual
	\$45/Family	\$45/Family

Mental Health

Substance Abuse

Precert Requirements

Yes

Yes

CoPay Amount

\$40

\$40

Coinsurance Amount

N/A

N/A

■ Outpatient

Deductible Amounts

\$25/Individual

\$25/Individual

\$45/Family

\$45/Family

Mental Health

Precert Requirements

Yes

Yes

CoPay Amount

\$40

\$40

Coinsurance Amount

N/A

N/A

Substance Abuse

Precert Requirements

Yes

Yes

CoPay Amount

\$40

\$40

Coinsurance Amount

N/A

N/A

■ EAP

Precert Requirements

Yes

Visit Limit

5 visits/per provider/per year

Send Inquiry

Member's Authorizations

Member's Claims




Enter Claim

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Authorizations Search Results

Authorization			Patient ID #	Case			Servicing Provider
View Letter	Number	Status 		Number	Begin Date	End Date	
	01 120101 23001 23680	Open	1234567891	123 555678	12/06/2004	12/06/2005	Wrightway HC
	01 120101 23001 87643	Open	1234567892	123 456777	01/02/2003	05/06/2004	Wrightway HC
	01 120101 23001 76556	Open	1234567893	123 445566	01/02/2003	05/06/2004	Wrightway HC

The information displayed indicates the most current information we have on file. It may not reflect claims or other information that has not been received by ValueOptions.

Auth Summary

Auth Detail Lines

Associated Claims

The information displayed indicates the most current information we have on file. It may not reflect claims or other information that have not been received by ValueOptions.

Authorization Header

Member ID	1234567890
Authorization #	01 120101 23001 23680
Authorization Status	Approved
From Provider	Joe Provider
Begin Date	01/02/2003
End Date	03/31/2003

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The information displayed indicates the most current information we have on file. It may not reflect claims or other information that has not been received by ValueOptions.

Detail Header

Member ID **1234567890**

Authorization # **01 120101 23001 23680**

Authorization Status **Approved**

Service Lines

Line No	Svc Code	Effective/ Expiration	Requested/ Approved	Actual Used (as of 1/24/2005 05/26/2005)	Status
1	90801	9/03/2003 12/31/2003	1 1	0	Open
2	90862	9/30/2003 12/31/2003	2 2	2	Open
3	90805	9/30/2003 12/31/2003	1 1	0	Open
4	90808	1/1/2004 12/31/2004	6 6	3	Open
5	90862	1/1/2004 12/31/2004	6 6	0	Open

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Associated Claims List

Member ID	Claim Number	ICN Number	Service Date From	Service Date To
123456789	123 456789 01234 87345	9988776655	11/02/2003	05/02/2004
123456789	123 456789 01234 87345	9988776655	11/02/2003	05/02/2004
123456789	123 456789 01234 87345	9988776655	11/02/2003	05/02/2004
123456789	123 456789 01234 87345	9988776655	11/02/2003	05/02/2004
123456789	123 456789 01234 87345	9988776655	11/02/2003	05/02/2004

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Claim Detail

Claim # ABCDEFG-123
Claim Status [?](#) **In Process**
Patient Account # 123456789
Member # 0123456789
Member Address 4321 E. Blackwell St.
 Buffalo, NY
Provider Name Wrightway Medical Assoc.
Provider Organization PORG-12345
Group Name Mental Health Group
Statement Dates 01/01/2004 - 12/31/2004

Service Lines

Service Line #	Dates of Service	Type of Service	Procedure Code	Charged Amount 05/25/2005
1	11/02/2003 - 11/02/2003	1	A7890	\$ 284.56
2	11/02/2003 - 11/05/2003	9	A7891	\$ 500.00
3	11/04/2003 - 11/05/2003	1	A7892	\$ 450.00



Claim Summary Service Line Detail

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Claim Detail

Claim # **ABCDEFGG-123**

Claim Status **In Process**

Member # **0123456789**

Member Name **Burgandy, Robbie Jr.**

Amount Paid **\$1234.56**

Service Line Detail

Line	Service Date		Procedure Code/Modifier	Units	Charged Amount \$ 05/25/2005	DX	Amount Paid	Status	Dollar Amounts(\$)				Paid Date	Check#	EOP
	Start Date	End Date							Allowed	Deductible	COIN	CoPay			
1	07/01/2004	07/01/2004	90806	01	100.00	309.81	0.00	In Process	100.00	0.00	0.00	20.00			123
2	07/01/2004	07/01/2004	90806	01	100.00	309.81	0.00	Paid	50.00	0.00	0.00	10.00			345
3	07/01/2004	07/01/2004	90806	02	100.00	311.04	0.00	Denied	250.00	0.00	0.00	20.00			
4	07/01/2004	07/01/2004	90806	01	100.00	308.11	0.00	In Process	150.00	0.00	0.00	20.00			

Explanation of Payment

EOP code	Explanation Text
123	Text description for EOP code indicating explanation of payment
345	Text description for EOP code indicating explanation of payment

Send Inquiry

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Customer Service Inquiry

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

Authorization information has been captured for Inquiry. Please provide additional information with the form below to complete your inquiry.

Current Authorization

Authorization Number	01 120101 23001 23680
Service Date From	02/03/2004
Service Date To	06/03/2004
Authorization Status	Open
Patient Number	123 4567 8901
Provider Name	Joe Provider
Patient Name	Burgundy, Robert J.

Contact Details

Provider ID	987 6543 2100
Provider Name	Joe Provider

Contact Name
(if other than provider)

How should we get back to you?

E-Mail

Fax Number

(NNN-NNN-NNNN, 10-digit format)

Phone Number

(NNN-NNN-NNNN, 10-digit format)

*State your reason for the Inquiry:

Need to discuss an extension on this auth.
Please contact me.

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EDI Transactions

Batch Submission. To submit files, use the option below.

Search Files. Find & review the status of submitted files.

Note:** In order to activate Provider account, complete [Account Request Form](#) and return it. *Signature must be on file.**

Previous Claims File Batch Submissions

Submission Number	Form	Result	Received On
00511002199	837i	Passed Validation	03/24/2004
00511002172	837p	Failed Validation	03/24/2004
00511002121	837i	Passed Validation	03/03/2004
00511002002	837i	Passed Validation	02/28/2004
00511000764	837p	Passed Validation	01/30/2004

Incoming Files

File Name	Date Posted	Size
eclaims_redesign_proposal	05/03/2004 06:41:44 PM	528384 Bytes
0048020001	07/15/2004 03:11:25 PM	974 Bytes
signofflog.pdf	08/10/2004 04:05:25 PM	20992 Bytes
0068030001	09/17/2004 05:05:15 PM	98816 Bytes
0094527001	09/17/2004 05:06:23 PM	26 Bytes

Clinical Services

Clinical Philosophy

- Offer easy and immediate access to the most appropriate, high quality behavioral health services for Members.
- Work collaboratively with Providers in delivering Medically Necessary and effective care with minimal administrative barriers.
- Manage care from the point of entry through discharge.

Medical Necessity Criteria

- Used to make admission, level of care, and continuing treatment decisions.
- Reflects *ValueOptions* philosophy and clinical values.
- Sources include:
 - The American Psychiatric Association (APA) Manual for Peer Review
 - The Diagnostic and Statistical Manual IV.
 - The American Accreditation HealthCare Commission/ URAC Standards.
 - For Substance Abuse, *ValueOptions* has adopted the American Society of Addiction Medicine (ASAM) criteria.
- Available in the Provider Handbook, or on the *ValueOptions* Internet web site: www.valueoptions.com

Authorization Process -- HLOC

- Call 800# to verify eligibility
- Complete ITR (Inpatient Treatment Report)
- Care Manager will call back with auth decision
- Auth letter will be system-generated
- Fax updated ITR at time of discharge
- Course of treatment authorizations

Authorization Process -- OP

- Call 800# to verify eligibility and obtain initial authorization by CSR
- Complete OTR (Outpatient Treatment Report) if necessary
- Auth letter will be system-generated
- Course of treatment authorizations
- No micro-management

Evaluating Continued Care

- Clinical Care Manager (CCM) and Attending Provider confirm that continued care meets Medical Necessity.
- Includes an evaluation to determine if:
 - Progress is evident and continued level of care is necessary to sustain progress.
 - Continued treatment at current level of care can be expected to result in relief of symptoms.
 - Goals and timeframes are realistic/ appropriate.
 - Treatment at the current level of care is the most appropriate and least restrictive for the Member's condition and goals.

Benefits

- Fewer phone calls
- Standardized process across service centers
- Reduced micro-management
- Simplified data transmission (fax, email, web)
- Comprehensive data sharing with individual facilities to foster “best practice” self-management
- Course of treatment authorizations

Claims

Claims Overview

Objective

ValueOptions is striving to provide information to providers as a way to offer a better understanding of our mission to ensure timely and efficient processing of claims.

Items for Discussion

- Provide guidance to provider education with regards to *ValueOptions*' Policies and Procedures.
- Provide helpful information to assist in decreasing turn around time on claim reimbursements.
- Answer provider questions about claim submissions.

When Seeing a New Patient

- Contact *ValueOptions*' Benefits Line to verify patient eligibility and covered services at number on the member's card.
- Submit your "clean" claims to *ValueOptions* for consideration.

Claims Submission Guidelines

- Clean claims should be submitted on one of the two National Industry Standard billing forms:
- Center for Medicare and Medicaid Services – CMS-1500
 - (formerly know as the HCFA 1500)
- Or
 - Uniform Billing Form – UB92 or HCFA 1450
- Your submission of typed claims on the Standard Red CMS – 1500/UB92 claim forms will assist *ValueOptions* processing and remitting payment to providers in an accurate and timely manner

Submitting Clean Claims

Clean Claims

- UB92 or CMS-1500 submitted by the provider for care rendered to a covered member which contains all required information to accurately process a claim.
- The claim must contain the national basis of Current Codes; which means it must reflect the HIPAA compliant CPT, Revenue, HCPCS and ICD-9 codes in effect on October 16, 2003.
- The claim will also have no defect or impropriety (including any lack of substantial documentation) which may prevent timely payment on the claim.

Claims Address and Phone Number

Call the number on the member's insurance card

Required Information, CMS-1500

- Covered Member's Identification Number (Box 1a)
- Patient's Name (Box 2) and Address (Box 5)
- Patient's Date of Birth (Box 3)
- Insured's Name (Box 4) and Address (Box 7)
- Patients Relationship to the Insured (Box 6)
- Other Insurance Information, if applicable
- Diagnosis (Box 21a)
- Dates and Place of service (Box 24A and B)
- Current CPT code (Box 24D)
- Provider's Charges (Box 24F)
- Number of Days or Units (Box 24G)
- Providers Federal Tax Identification Number (Box 25)
- Provider's Name and Licensure, Signature (Box 31)
- Service Location (Box 32)
- Provider's Billing Address (Box 33)

Required Information, UB92

- Facilities name and Address (Box 1)
- Type of Bill (Box 4)
- Facilities 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)
- Discharge Hour (Box 21)
- Patient's Status (Box 22)
- Responsible Party Name and Address (Box 38)
- Contracted Revenue Codes (Box 42)
- HCPCS Code, if applicable (Box 44)
- Service Date, when using HCPCS Codes (Box 45)
- Service Units (Box 46)
- Total Charges (Box 47)
- Payer (Box 50 a,b,c)
- Release of Information Certification Indicator (52 a,b,c)
- Assignment of Benefits (Box 53 a,b,c)
- Insured's Name (58 a,b,c)
- Patients 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 Physicians Identification Number, Name and Licensure Level (Box 82)
- Provider Representative (Box 85)
- Date (Box 86)

Incomplete & Non-Clean Claims

- Invalid or Missing Information

If a claim is received that is missing information, it will be denied on the provider's summary voucher with a request to resubmit the information needed to process the claim.

- Unable to Locate the Patient Eligibility

ValueOptions will take the necessary steps to diligently locate the patients active coverage. However, when we are unable to do so based on the information provided, the claim will be denied on the provider's summary voucher. The patient's name from the claim will be documented in the "patient account number" field, as well as any patient account number provided. The Provider or Facility should then contact the Patient for verification of the Member's Identification Number, correct the claim and resubmit a new claim for consideration.

Electronic Claims Submission

- *ValueOptions* encourages providers to sign up for electronic claims submissions, or, for the smaller provider offices, single claim submissions.
- These services offer many benefits in comparison to paper submission by reducing associated costs such as forms, purchase, labor, postage, human error, etc.
- Claims filed electronically or through our web-site are received and processed quicker on average.
- Additional benefits:
 - *ValueOptions*' Online Provider Services is designed to give providers easy access to eligibility inquiry, claims status inquiry, and electronic claim submission.
 - These services are provided at no cost to our Network Providers.
- The EDI Help Desk number is:

(888) 247-9311

Timely Filing

- Participating providers are required to file “Clean Claims” within 90 days from the date of service.
- Failure to file claims will result in non-payment.
- Providers that have not received payment or denial on a filed claim within 30 to 40 days should contact *ValueOptions* to verify claim receipt and status.

Claims Processing/Payment

Target Standard for Claims Processing

- Clean Claim

ValueOptions is required to process 90% of clean claims within 15 business days of receipt

- All Claims

ValueOptions is required to process 100% of all claims within 30 business days of receipt

Prompt Pay

- *ValueOptions* will process claims in accordance with the clients performance expectations and state prompt pay requirements.

Claims Inquiries and FAQ's

Inquiries

- Providers that have questions in regards to a claim payment or claim denial should contact *ValueOptions* by calling the number on the back of the member's ID card.

I've submitted a claim and it was denied. What do I do?

Depending on why the claim was denied, you would want to either resubmit a "corrected" claim or file an appeal.

A corrected claim is appropriate when the claim was denied due to lack of or inaccurate information originally provided on the claim form.

Example:

- Missing Diagnosis
- Incorrect CPT billed
- Incorrect Member Identification Number

Claims Inquiries and FAQ's (cont.)

I have not received a payment. What do I do?

- If a provider or facility fails to receive a payment or denial from *ValueOptions* within 30 to 40 days, a call should be made to inquire as to the status of the claim.
- If the claim is not on file, it should be resubmitted for consideration.
- If the claim was received, but was unable to be processed, the provider or facility should make the necessary corrections and resend a “corrected claim”.

My claims denied for no certification, but it is now on file.

What do I do?

- In cases such as this, a Provider or Facility should contact *ValueOptions* to speak with a Claims Customer Service Representative to initiate an inquiry.

Questions....



FRAUD AND ABUSE



Fighting fraud and abuse strengthens and preserves *ValueOptions*' services to providers and members and enhances the health care delivery system as a whole.

Abuse

- *ValueOptions* defines abuse as any practice, direct or indirect, that is inconsistent with sound or established fiscal, business, insurance, or medical practices and results in an unnecessary cost to a behavioral health benefits program.
- It also consists of reimbursement for services performed that are not medically necessary or that fail to meet professionally recognized standards for health care.
- A provider may or may not have knowingly and/or intentionally misrepresented facts to obtain payment.
- Abuse also includes any practices by a member that results in unnecessary costs to a behavioral health program.

Fraud

- *ValueOptions* defines fraud as an intentional deception or misrepresentation made by an entity or person in any managed care setting with the knowledge that the deception could result in some unauthorized benefit to the entity, himself/herself, or some other person.
- In the context of health care claims, purposely billing for services that were never given, for a service that has a higher reimbursement than the service provided, or at the incorrect reimbursement level.

Common Examples of Fraud and Abuse

- Submitting claims for services that were not provided (this includes no shows or canceled appointments)
- Misrepresenting the diagnosis for the member in order to justify payment
- Utilizing split billing schemes (i.e., billing procedures over a period of days when all treatment occurred during one visit)
- Coding a service at a higher level than what was rendered (i.e. up-coding)

Common Examples of Fraud and Abuse Continued

- Inappropriate documentation of services rendered
- Billing for all participants of a family therapy session
- Billing for services by a provider for services actually rendered by an affiliated (i.e. employed or associated with same group etc.) provider who is not a contracted or credentialed provider of *ValueOptions*.

When Fraud is Committed . . .

Automatic Termination

Providers will be immediately terminated upon the happening of any of the following events:

- **Insolvency or Dissolution**
- **Loss of License**
- **Conviction of Fraud**
- **Limited Ability to Practice**
- **Death**

Eliminating Fraud and Abuse

To eliminate fraud and abuse successfully, providers, facilities, and members must work together to prevent and identify inappropriate and potentially fraudulent billings.

This can only occur by:

- Monitoring claims submitted for compliance with billing guidelines
- Adherence by providers and facilities to Treatment Record Standards
- Education of all staff members responsible for dealing with medical records (including documentation, storage, retrieval, or review) or who are involved with billing
- Referring cases of suspected fraud and abuse

For More Information

- Contact Us
 - FHC Ethics and HIPAA Hotline at 1-888-293-3027.
- Visit our Website
 - www.valueoptions.com

Questions....

Thank You!