

## **FREQUENTLY ASKED QUESTIONS ABOUT MENTAL HEALTH PARITY**

### **GENERAL INFORMATION**

**Question: What is Mental Health Parity?**

**Answer:** The Mental Health Parity and Addiction Equity Act of 2008 aligns mental health/substance abuse (MHSA) benefits and medical/surgical benefits for group health plans with more than 50 employees. The historic legislation of the Mental Health Parity Act makes the equal treatment of mental health and physical health an achievable reality.

**Question: Does the parity law apply to collectively bargained plans?**

**Answer:** Yes. Collectively bargained plans need to comply with parity based on the provisions of the next bargaining agreement.

**Question: Does the parity law apply to Medicare Advantage plans?**

**Answer:** At this time, members of Medicare Advantage are not subject to the provisions of Federal Mental Health Parity and should not anticipate changes to current clinical management processes (e.g., prior authorization, other utilization management).

**Question: Does the parity law apply to Medicaid Managed Care plans?**

**Answer:** Yes. Medicaid managed care plans are subject to the provisions of parity and additional guidelines will be forthcoming from Centers for Medicare and Medicaid Services (CMS).

**Question: Does the parity law apply to employee assistance programs (EAP) and health and wellness benefits?**

**Answer:** The parity law was not written with these benefits in mind, and it is likely that regulations will clarify that these benefits should not be understood as "group health plans" or "health insurance coverage" that is the focus of the law. Until regulatory guidance is available, it is reasonable to assume that the parity law does not apply to EAP and health and wellness programs.

**Question: What is the best way for providers to check a member's benefits that participates with ValueOptions®?**

**Answer:** It will be critical for providers to check with their patients for any services provided early in the year on the new benefits as co-pays, co-insurances and other key benefits may have changed as a result of the new plan year. We have been working with our customers on making the changes according to their existing plans and that they can

contact ValueOptions<sup>®</sup> for any clarification on benefit modifications related to parity for members that they are seeing.

It is important that providers verify a patient's benefit plan prior to requesting services via ProviderConnect<sup>SM</sup>. **Members' benefits can be accessed via** ProviderConnect<sup>SM</sup> or by calling the appropriate telephone number located on the back of the member's benefit card.

**Question: Does the parity law mandate that all diagnoses in the DSM-IV-TR be covered at the parity level?**

**Answer:** The law does not require that all MHSA conditions be covered. However, once an employer or other payer decides to cover a MHSA condition, then that coverage must be on par with the medical-surgical benefit. Some payers/group health plans may decide to exclude certain MHSA diagnoses. As always, claims are filed as ICD-9.

**Question: The parity law states that MHSA benefits must include out-of-network coverage if such benefits are included as part of the medical benefit. Can out-of-network care be managed under the parity law or is it an unmanaged benefit?**

**Answer:** MHSA benefits must include out-of-network coverage if such coverage is part of the medical benefit. MHSA benefits are provided according to "the terms and conditions of the plan," and the out-of-network benefit must be consistent with this requirement. That is to say that the plan can require management protocols (e.g., utilization review, adherence to practice guidelines, adherence to medical necessity criteria) under the terms and conditions of the plan, and these management protocols can be applied to both in-network and out-of-network providers.

**Question: What changes are implemented by the act?**

**Answer:** The passage of the Mental Health Parity and Addiction Equity Act of 2008 requires that group health plans that offer substance abuse and mental health treatment benefits guarantee that the scope of the benefits is equal to the plans coverage of medical and surgical benefits.

**Question: Why the act is significant to providers?**

**Answer:** The passage of the long-awaited Mental Health Parity Act law has made MHSA (Mental Health and Substance Abuse) providers curious as to how this will affect them. Since group health plans can sometimes limit the number of mental health or substance abuse treatment visits a member may make, with the passing of Parity, if there aren't any limits on how often a member may see their non-behavioral health practitioner (i.e. their primary care doctor or surgeon) then the mental health/substance benefit cannot have limits on number of visits. However, medical necessity standards, practice guidelines and utilization review protocols still apply.

**Question: What is ValueOptions® doing to prepare their providers for the Parity Act?**

**Answer:** Our Provider Relations department will be publishing articles in our monthly e-newsletter to update our providers on the changes associated with the Parity Act. Our Provider Relations Customer Service Line will also be able to answer any questions. You can reach the Provider Relations Customer Service Line by calling 800-397-1630 between 8AM and 5PM Eastern Time.

**Question: Is there anything the new Parity Act does not explain?**

**Answer:** Although the benefit may be available, where applicable, treatment is still subject to medical necessity. ValueOptions® is here to support your transition and continued success in the new era of parity. For more information, please contact our Provider Relations Customer Service Line at 800-397-1630 between 8AM and 5PM Eastern Time.

**Question: Where can I find additional information about the Mental Health Parity?**

**Answer:** There are both state and federal laws regarding mental health parity. Information about the New York mental health parity law (Timothy's Law) is available on the New York State Insurance Department web site at <http://www.ins.state.ny.us/timothy.htm>.

The CMS website has information about the federal mental health parity for consumers at [http://www.cms.hhs.gov/healthinsreformforconsume/04\\_thementalhealthparityact.asp](http://www.cms.hhs.gov/healthinsreformforconsume/04_thementalhealthparityact.asp).

The name of the federal act is: The Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008. It is located in Section 512 of the Emergency Economic Stabilization Act. The following link is to this Section 512: <http://www.ncsl.org/Default.aspx?TabId=14064>.

*DISCLAIMER: Please be aware that these sites do not serve as or are in no way legal advice and should a provider have questions regarding this law he/she should consult legal counsel of their choosing, and that ValueOptions® is not responsible for the information available on any such websites or for provider's access to information through such website links.*

### **INPATIENT CARE**

**Question: What is going to change in terms of Inpatient and all Alternative Levels of Care (ALOC)?**

**Answer:** When applicable, ValueOptions® will follow client specific notification or precertification guidelines according to an Employer's benefit design. Most plans administered by ValueOptions® will continue to require either precertification of care or

notification to ValueOptions® within 24-48 hours of a member's admission to inpatient mental health or substance abuse treatment facility including alternative levels of care. Please note that ALOC includes partial hospitalization and intensive outpatient programs for the treatment of either mental health or substance abuse illnesses. Notice can be provided via ProviderConnect<sup>SM</sup> using the request for services function or by calling the appropriate telephone number on the back of the member's benefit card. Failure to provide notification as required by the benefit plan may result in penalties being applied as follows:

- Claims payment may be made at a reduced rate,
- Services may be subject to an additional deductible,
- Denial of coverage.

Dates of service may be denied if you fail to provide notification as required by the benefit plan and claims are submitted for services that have not yet been reviewed. In these situations, ValueOptions® will allow retrospective reviews as permitted in accordance with the terms and conditions of the contract. When retrospective reviews are conducted, it is expected that medical records will be furnished upon request. In the instance that complete medical records are not provided, providers should expect administrative denials to be applied to claims submitted. ValueOptions® is required to make medical necessity determinations.

### **OUTPATIENT CARE**

#### **Question: What is going to change in terms of Outpatient Care?**

**Answer:** With regard to Outpatient Therapy Services, for most plans that are affected by FMHP, authorization prior to beginning treatment is no longer required. In place of the current pass through/registration processes for outpatient services, ValueOptions® will initiate an outlier care management model. The outlier model will focus on individual cases by diagnostic category where the course of treatment varies significantly from expected norms. For plans that are not impacted by FMHP, current model of pass through/registration will continue. As always, benefits vary by client for what is a covered benefit and what requires an authorization. We remind you of the importance of reviewing your member's benefit on the benefits tab on ProviderConnect<sup>SM</sup> or by calling the appropriate telephone number located on the back of the member's benefit card.

If a case is identified as an outlier, ValueOptions® will request additional clinical information about the member's treatment in order to conduct appropriate utilization management. Similarly, if an individual provider's treatment patterns within a diagnosis varies significantly from expected norms, additional information may be requested.

In these cases, an outpatient review will be requested via your ProviderConnect<sup>SM</sup> Message Center. If you are not registered online we encourage you to do so. If you do not have a ProviderConnect<sup>SM</sup> account, you will receive a letter with an outpatient review to complete.

**Question: If an authorization is not required, will ValueOptions<sup>®</sup> enter an authorization if requested by a provider?**

**Answer:** No. If an authorization is not required, ValueOptions<sup>®</sup> will not enter an authorization.

**Question: Will ValueOptions<sup>®</sup> request clinical information when the benefit doesn't require precertification for authorizations?**

**Answer:** Yes. Although, the benefit design doesn't require precertification for outpatient treatment it does require treatment be medically necessary. ValueOptions<sup>®</sup> has preselected specific types of outpatient cases for more intensive review and care management. If it is determined that additional information is required for a particular member a request for that additional information will be sent to the provider requesting the review be completed and submitted. In-network providers can complete clinical reviews online. Out-of-network providers can fax the Outpatient Review to ValueOptions<sup>®</sup>.

**Question: What types of outpatient cases are being selected for more intensive review and case management?**

**Answer:** ValueOptions<sup>®</sup> outpatient medical necessity review process includes review of specific high risk and outlier cases based on diagnosis and treatment based guidelines appropriate standards. This may vary over time and by account. ValueOptions<sup>®</sup> treatment guidelines can be found on ValueOptions.com at the following link: [http://www.valueoptions.com/providers/Handbook/treatment\\_guidelines.htm](http://www.valueoptions.com/providers/Handbook/treatment_guidelines.htm)

**Question: How many sessions can I use before a case is considered an outlier case?**

**Answer:** ValueOptions<sup>®</sup> identifies high risk diagnostic categories and outliers through ongoing analytical reviews. The number of sessions that can be utilized prior to a request for additional information varies by the diagnostic categories.

**Question: What will happen if I fail to respond to the request for clinical information?**

**Answer:** A denial will be issued for further treatment services. Denials will be issued with appropriate appeal options.

**Question: Does the outlier model apply to psychological testing?**

**Answer:** No. Psychological testing is considered a specialized service and may still require authorization prior to the testing occurring based on the member's medical plan requirements.

**Question: If a member's plan has not moved to FMHP then we must complete an outlier review?**

**Answer:** No. If the plan has not moved to FMHP, there will be no change to the current Outpatient review process. Pass through sessions, if applicable, followed by Outpatient Review submission stays the same.

**Question: I am familiar with Parity pertaining to serious mental illness diagnoses, however, this sounds like it will apply to ALL mental health claims regardless of diagnosis, is that correct?**

**Answer:** FMHP act does not differentiate by diagnosis as some State Regulations do. The law applies to all diagnoses that the plan covers. A plan may choose not to cover a specific diagnosis. All plans affected must comply with the law.

**Question: Will the provider be notified by ValueOptions® if the patient goes to the Emergency Room (ER) for Behavioral Health purposes or will a ValueOptions® representative inform the ER staff about the patient's ongoing treatment with an Outpatient Behavioral Health provider? Will the current Behavioral Health provider be advised of past behavioral health diagnoses or concurrent diagnoses?**

**Answer:** If a member is seen in an ER, and ValueOptions® is aware, ValueOptions® will notify the current treating provider. ValueOptions® cannot release past information to a current provider.

**Question: Is there a new/revised Outpatient Review for 2011 with regard to FMHP?**

**Answer:** Yes, the form is now called the **Outpatient Review** and has been revised with a new treatment guideline section. Providers can start using the new form as of January 1, 2011.

**Question: When does a provider have to fill out/submit an Outpatient Review?**

**Answer:** For plans that are subject to parity, a provider will submit an Outpatient Review when requested by ValueOptions®. If a case is identified as an outlier, ValueOptions® will request additional clinical information about the member's treatment and that ValueOptions® needs the provider to fill out/submit an Outpatient Review to supply the additional clinical information. For plans not subject to Parity, providers will continue to follow the same procedures as they were following for that member.

**Question: Does the Federal Parity regulations allow ValueOptions® to request an Outpatient Review? How do we submit the Outpatient Review? Where is the Outpatient Review document located?**



**Answer:** Yes. Parity allows for medical necessity review. ValueOptions® is asking for an Outpatient Review as a part of the medical necessity review process.

The Outpatient Review can be submitted Online, via fax or a paper copy can be mailed via USPS.

The Outpatient Review document can be found on the following section of the provider website: <http://www.valueoptions.com/providers/Clinforms.htm>

### **MEMBER BENEFIT PLAN & ELIGIBILITY INFORMATION**

**Question:** How will we know which ValueOptions® plans require outpatient authorizations and which ones don't require outpatient authorizations?

**Answer:** Benefits must be verified for each member. Please read the additional questions below for how to check benefits.

**Question: Is there anything online we can look at that will give us the plans that have changed?**

**Answer:** ValueOptions® will have "Benefits at a Glance" available for each client. Providers can also call the number on the back of the member's insurance card or check with members regarding member benefit information. Please call ValueOptions® for specific benefit details and information.

***PLEASE NOTE: NOTIFICATION AND REVIEW REQUIREMENTS MAY CHANGE OR BE MODIFIED TO BE IN LINE WITH MEDICAL PLANS.***

**Question: Are letters being mailed to providers letting them know which of their patient's plans have changed?**

**Answer:** The ValueOptions® Provider eNewsletter is the best way for providers to learn about general and plan specific FMHP changes and updates.

**Question: Are there certain group numbers that are changing?**

**Answer:** It is possible that the group number will change. Providers can check for group number changes on ProviderConnect<sup>SM</sup> or call the number on the back of the member's insurance card

**Question: When will all the rest of the benefit plans change to this parity benefit?**

**Answer:** FMHP benefit changes are going to occur based on the vendor contracts. Although many plan specific contracts convert upon plan year, accounts will transition based on their FMHP compliance date.

Collectively bargained plans do need to comply with parity based on the provisions of the next bargaining agreement. At this time, members of Medicare Advantage are not subject to the provisions of Federal Mental Health Parity and should not anticipate changes to current clinical management processes (e.g., prior authorization, other utilization management). Medicaid managed care plans are subject to the provisions of parity and additional guidelines will be forthcoming from Centers for Medicare and Medicaid Services (CMS).

**Question: When we look at benefits online, can I tell that the new parity benefit applies to that patient?**

**Answer:** Parity and other benefit updates will be available online via “Benefits at a Glance”. Online benefit information is uploaded based on information received from the client. If you would like more extensive information on benefits, please call the number on the back of the member’s card.

## CLAIMS

**Question: What is a Threshold Claim?**

**Answer:** When a provider has submitted claims that reach a quantity for a specific diagnostic category the system considers this a threshold claim. This signifies that a medical necessity review is now required as this particular case has varied from expected norms for the diagnostic category. At that time ValueOptions® will be requesting additional clinical information to determine medical necessity for the payment of ongoing services. An outpatient review is required.

**Providers will receive a notice, similar to the following, on their Provider Summary Voucher only when a case is considered an outlier case or when an inpatient or higher level of care provider/facility fails to notify ValueOptions® of an admission:** Medical Records are required for consideration of your claim. Upon receipt and review of your patient’s medical records, the claim will be processed and you will receive notification of the benefit determination. If you are a ValueOptions® contracted provider, you should not bill your patient as a result of this request for medical records.

## OUT-OF-NETWORK PROVIDERS

**Question:** What does an out-of-network provider need to do if they have a member transitioning coverage to ValueOptions<sup>®</sup>?

**Answer:** Out-of-network providers with members transitioning to ValueOptions<sup>®</sup> coverage need to call the toll-free number on the back of the member's insurance card.

**Question:** If a provider is not contracted or considered out-of-network with ValueOptions<sup>®</sup>, do they get access to ProviderConnect<sup>SM</sup>?

**Answer:** Out-of-network providers have all viewing and inquiry capabilities. Some out-of-network providers have the ability to submit claims. *Please note - ProviderConnect<sup>SM</sup> may look different and have different functionalities based on individual contract needs, therefore some functions may not be available or may look different for the specific contract.*

### PROVIDERCONNECT<sup>SM</sup>

**Question:** If you are not registered as a ProviderConnect<sup>SM</sup> user is there another way to communicate outlier cases and threshold claims to us?

**Answer:** While we urge providers to use ProviderConnect<sup>SM</sup>, providers that do not have an active account on ProviderConnect<sup>SM</sup> will receive letters in the mail.

**Question:** Will providers have a way to submit acknowledgement of treatment guidelines other than via the ProviderConnect<sup>SM</sup> website, such as fax?

**Answer:** While we urge providers to use ProviderConnect<sup>SM</sup>, providers can still fax, mail, or complete telephonic reviews.

**Question:** We are a large provider practice. We have a facility contract. Do we have to get one login for each provider and monitor all logins for messages in ProviderConnect<sup>SM</sup>? Or can we have one login for our tax id with all messages for all providers?

**Answer:** For facility contracts, use the facility login.

**Question:** I run a large practice and it is difficult to keep track of all of the clinician's ProviderConnect<sup>SM</sup> message centers. Will we get an email telling us we have a message in our message center?

**Answer:** Notifications will be sent to "provider accounts", only.

You will receive notifications via email if you have an active account, a valid email address in your Provider Connect profile and have elected to receive emails when you set your Provider Connect profile. If you have not elected to receive emails, your notification will be available for viewing in your Message Center In-Box.

**Question:** Will the threshold claim request come to the person entering the claim in ProviderConnect<sup>SM</sup> ?

**Answer:** No. The inquiry will be pended to the ProviderConnect<sup>SM</sup> Message Center Inbox for the provider id.

**Question:** I run a large practice with many clinicians. Will we receive an email telling us when we have a message in our message center on ProviderConnect<sup>SM</sup> ?

**Answer:** Yes, if you have the option for email notifications selected in your ProviderConnect<sup>SM</sup> online profile you will receive email notifications.

**Question:** If a provider has an active account but does not frequently use or check ProviderConnect<sup>SM</sup> will they get a letter in the mail instead of a message in their ProviderConnect<sup>SM</sup> Message Center?

**Answer:** In general, if a Provider has an active account they will not get a letter in the mail. There are some correspondence types that will not be sent electronically. Your ProviderConnect<sup>SM</sup> account is active if you are able to log in. If your account is not active, you will receive a message that the account has been disabled. If you have technical questions regarding your Provider Connect account, please contact the EDI help desk at 888-247-9311.

**Question:** Am I supposed to receive a red error message when I go to the “Outpatient Review” screen on ProviderConnect<sup>SM</sup> ?

**Answer:** If you are receiving a red error message indicating to select the Outpatient Outlier level of care when initiating an "Outpatient Review" on ProviderConnect<sup>sm</sup>, that is the system's way of alerting you that NO authorization is required and you do not need to continue with the review, unless you have received a specific request for an outlier review, as the member's plan has moved to Parity. The member's benefit information can be obtained in ProviderConnect<sup>SM</sup> on the member's benefit tab.



## **MEDICAL RECORDS**

**Question:** Because medical records are required for consideration of an outlier claim, can I bill ValueOptions or the member as a result of this request for medical records?

**Answer:** No. As a ValueOptions<sup>®</sup> contracted provider, you are prohibited from billing ValueOptions<sup>®</sup> or our members as a result of requests for medical records.

For further clarification regarding the “no reimbursement for medical records” language please reference the Provider Handbook and Contract resources:

- **Section 6.0 (page 16) of the Provider Handbook**, *unless otherwise specifically provided for in provider agreement, access to and any copies of member treatment records requested by ValueOptions or designees of ValueOptions shall be at no cost. Please see: <http://www.valueoptions.com/providers/Handbook.htm>*
- **Section 5.2 of the current ValueOptions<sup>®</sup> standard Agreement**, *copies of medical records requested shall be provided at no cost to ValueOptions<sup>®</sup> or any Payor.*