

■ ■ ■ VALUEOPTIONS PROVIDER HANDBOOK

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Appendix 1: [Handbook Glossary](#)

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Appendix 3: [State/Government Program/Network Specific Provision and/or Supplements](#)

Appendix 4: [Medicare Advantage Specific Provisions](#)

Appendix 5: [EAP Handbook](#)

Overview

Welcome to the ValueOptions®^{1,2} network of *participating providers*. This *handbook* is an extension of the *provider agreement* and includes guidelines on doing business with ValueOptions, including policies and procedures for individual providers, affiliates, group practices, programs and facilities.

Together, the *provider agreement*, addenda, and this *handbook* outline the requirements and procedures applicable to *participating providers* in the ValueOptions network(s).

Italicized terms are terms included in the Glossary section of this *handbook* located in [Appendix 1](#).

Forms referenced in this *handbook* or in the *provider agreement* are available for download or printing through the 'Provider' section of the *website*.

Important Notice: Except to the extent a given section or provision in this *handbook* is included to address a regulatory, accreditation or government program requirement or specific benefit plan requirement, in the event of a conflict between a *member's* benefit plan, the *provider agreement* and this *handbook*, such conflict will be resolved by giving precedence in the following order: (1) the *member's* benefit plan, (2) the *provider agreement*, and (3) this *handbook*.

This *handbook* replaces in its entirety the previous version dated September 2009 and is available electronically at ValueOptions.com. Paper copies of this *handbook* are available upon written request.

Changes and updates to this *handbook*, *member* educational materials, news and other online services are posted and/or available through the 'Provider' section of the *website*. Changes and updates become binding sixty (60) days after notice is provided by mail or electronic means, or such other time as may be identified for compliance with statutory, regulatory and/or accreditation requirements to which ValueOptions is or may be subject.

Links to the *website*, other information and forms referenced throughout this *handbook* are included for convenience purposes only and such information and/or forms are subject to change without notice. *Participating providers* should access and download the most up-to-date information and/or forms from the *website* at the time needed.

Questions, comments and suggestions regarding this *handbook* should be directed to ValueOptions at (800) 397-1630.

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About ValueOptions

While ValueOptions, Inc. is licensed in numerous states as a third party administrator and/or utilization review agent of behavioral health services, some of the ValueOptions subsidiaries are licensed as full service or limited service health plans operating in a designated state.

¹ 'ValueOptions' is a registered service mark of ValueOptions, Inc. Any use of or reference to 'ValueOptions' in any communication, publication, notice, disclosure, mailing or other document, whether written or electronic, requires the prior written authorization of ValueOptions, Inc.

² This *handbook* applies to *participating providers* in provider network(s) maintained by ValueOptions, Inc. and/or its affiliates: ValueOptions of Arizona, Inc., ValueOptions of California, Inc., ValueOptions of Kansas, Inc., and ValueOptions of Tennessee, Inc., as well as to *participating providers* in the separate CHCS IPA, Inc. and Value Behavioral Health IPA of New York, Inc. networks. CHCS IPA, Inc. and Value Behavioral Health IPA of New York, Inc. are independent practice associations operating only in New York and are wholly owned subsidiaries of ValueOptions, Inc.

ValueOptions, through contracts with clients, manages and/or administers behavioral health and wellness benefits and services, including employee assistance programs, work/life services, wellness programs and mental health and substance abuse benefits and services in a wide array of settings. Today, clients include small and large companies, commercial, *Medicare Advantage* and managed *Medicaid* health plans, and state and local government programs and agencies. Additional information about ValueOptions is available on the *website*.

ValueOptions manages mental health and substance abuse services of benefit plans sponsored and/or administered, in whole or in part, by companies and organizations contracted with ValueOptions in compliance with applicable laws, rules and regulations, including without limitation the Federal Mental Health Parity and Addictions Equity Act, state parity laws and regulations. Subject to benefit plan requirements, inpatient *covered services* and other higher *levels of care* generally require prior *authorization/certification* or *notification* of the admission and outpatient *covered services* are reviewed for *medical necessity* after outlier thresholds are reached. Certain high risk or complex cases may require prior review and/or more intensive review and/or case management. Details of individual benefit plan requirements and procedures are available through ProviderConnect on the *website*.

ValueOptions is a major proponent of the "Recovery Model" philosophy of delivering integrated services to *members* with long term psychiatric disabilities and their families. A number of the local ValueOptions Service Centers sponsor consumer self-help groups, educational programs, drop-in centers, advocacy programs and other consumer-led activities that help people to become actively involved in achieving their highest possible level of functioning in their communities.

ValueOptions arranges for the provision of and access to a broad scope of behavioral health services for *members* through its provider networks, consisting of appropriately licensed and/or certified practitioners, facilities, providers, and programs offering varying *levels of service*.

ValueOptions does not specifically offer rewards or incentives, financial or otherwise, to its utilization management staff, contractors, *participating providers*, *Clinical Care Managers (CCMs)*, *Peer Advisors* or any other individuals or entities involved in making *medical necessity* determinations for issuing denials of coverage or service or that are intended to encourage determinations that result in underutilization. Utilization management decisions are based only on appropriateness of care and service and existence of coverage.

Information specific to *participating providers* in *EAP* networks is located in [Appendix 5](#).

Contact information is located in the "Contacts" section of this *handbook*. Additional information about the locations, email addresses, and toll-free numbers of ValueOptions' offices throughout the country are conveniently located at the *website*.

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Contact Information

<i>Administrative Appeal</i>	To request an <i>administrative appeal</i> , call the toll free number included in the administrative denial letter received.
<i>Adverse Incident</i>	Report all <i>adverse incidents</i> to the <i>Clinical Care Manager</i> with whom the <i>participating provider</i> conduct reviews.
Changing your <i>Provider Profile</i> (e.g. Name,	"Change of Address" forms can be found at the <i>website</i> and may be submitted by using one of the following options:

address)	<p>Fax: (866) 612-7795</p> <p>Mail Address: ValueOptions c/o Practitioner Maintenance P.O. Box 41055 Norfolk, VA 23541</p> <p><u>NOTE:</u> A change of address requires an accompanying W-9 form, a copy of which is available at the <i>website</i>.</p>
Claims - General Information	For questions about claims in general, call (800) 888-3944.
Claims Submission/ Address	Reference the address on the <i>member's</i> identification card, as the address may vary based on payment location.
<i>Clinical Appeals</i>	To request a clinical <i>appeal</i> on a <i>member's</i> behalf, call the toll-free number included in the adverse determination letter received.
Complaints/Grievances	To file a <i>complaint/grievance</i> , call the toll-free number on the back of the <i>member's</i> identification card to speak to Customer Service.
Credentialing Status	To obtain information pertaining to network participation status, contact ValueOptions' National Provider Line at (800) 397-1630 from 8am-5pm Eastern Standard Time.
Electronic Claims Submission (EDI)	<p>For technical questions about ProviderConnect or ValueOptions' EDI Claims Link software, please contact the EDI Help Desk at:</p> <p>Telephone: (888) 247-9311 from 8 am – 6 pm Eastern Standard Time</p> <p>Fax: (866) 698-6032</p> <p>E-mail: e-supportservices@valueoptions.com</p> <p>Mailing Address: ValueOptions Attn: EDI Helpdesk PO Box 1287 Latham , NY 12110</p>
Fraud and Abuse	<p>Reports of questionable billing practices or suspected fraud may be made in writing to:</p> <p>Mailing Address: ValueOptions, Inc. National Headquarters ATTN: Special Investigations Unit 240 Corporate Boulevard Norfolk, VA 23502</p>

	OR Contact ValueOptions Provider Services Line at (800) 397-1630 Monday through Friday, 8 a.m. to 5 p.m. EST.
<i>Member</i> Benefits, Eligibility, and Authorizations	For question about authorizations or benefits, call the toll-free number on the back of the <i>member's</i> identification card.
<i>Member</i> Customer Service	To reach <i>Member</i> Customer Service, call the toll-free number on the back of the <i>member's</i> identification card.
<i>Provider</i> Coverage During Absences	Contact the <i>Clinical Care Manager</i> with whom the <i>participating provider</i> conducts reviews during absences (i.e. coverage while on vacation). Or call the number on the <i>member's</i> card to provide coverage information.
<i>Website</i>	www.ValueOptions.com (select “ <i>providers</i> ”)

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ValueOptions.com

ValueOptions’ *website* (www.ValueOptions.com) contains information about ValueOptions and its business. Links to information and documents important to *providers* are located here at the ‘Provider’ section.

Access to ProviderConnect and Achieve Solutions® is available here as well.

ProviderConnect is a secure, password protected site where *participating providers* make conduct certain on-line activities with ValueOptions directly twenty four (24) hours a day, seven (7) days a week (excluding scheduled maintenance and unforeseen systems issues). Currently, *participating providers* provides access to the following on-line activities: *authorization* or *certification* requests for all levels of care, concurrent review requests and discharge reporting, single and multiple electronic claims submission, claim status review for both paper and electronic claims submitted to ValueOptions, verification of eligibility status, submission of inquiries to ValueOptions Provider Customer Service, updates to practice profiles/records, and electronic access to *authorization/certification* letters from ValueOptions and *provider summary vouchers*.

Achieve Solutions® is an educational behavioral health and wellness information web-site. This web-site is educational in nature and is not intended as a resource for emergency crisis situations or as a replacement for medical care or counseling.

Appendix 2 contains a list of ValueOptions forms available for download or printing through the ‘Provider’ section of the *website*.

ValueOptions’ Notice of Privacy of Practices regarding use of the *website* is located on the *website*.

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Participating Providers

ValueOptions does not refuse to contract with or terminate existing contractual relationships with *providers* because a provider: (a) advocates on behalf of a *member*, (b) files a complaint with or against ValueOptions, or (c) *appeals* a decision or determination made by ValueOptions.

Participating providers are independent contractors of ValueOptions. This means that *participating providers* practice and operate independently, are not employees of ValueOptions, and are not partners with or involved in a joint venture or similar arrangement with ValueOptions. ValueOptions does not direct, control or endorse health care or treatment rendered or to be rendered by *providers* or *participating providers*.

ValueOptions encourages *participating providers/providers* to communicate with *members* to discuss available treatment options, including medications and available options, regardless of coverage determinations made to or to be made by ValueOptions or a designee of ValueOptions. Treating *providers*, in conjunction with the *member* (or the *member's* legal representative), make decisions regarding what services and treatment are rendered. Any *preauthorization, certification or medical necessity* determinations by ValueOptions relate solely to payment. *Participating providers/providers* should direct *members* to ValueOptions or their respective benefit plan representatives for questions regarding coverage or limitations of coverage under their benefit plan prior to rendering *non-emergency* services.

ValueOptions Provider Identification Numbers

The ValueOptions provider number is a *participating provider's* unique six digit number (e.g. 123456). The *participating provider's* vendor number is a service location number where services are or were rendered. A *participating provider* may have multiple vendor locations and each vendor location is given a five-digit number preceded by the letter 'A'. (e.g. A23456). *Providers/participating providers* should contact ValueOptions National Provider Relations at (800) 397-1630 during normal business hours Monday through Friday, 8 a.m. to 5 p.m. EST for questions regarding Provider Identification Numbers and/or for assistance in obtaining a Provider Identification Number.

Provider Satisfaction Survey

ValueOptions conducts an annual provider satisfaction survey to measure *participating providers'* opinions regarding ValueOptions clinical and administrative processes. Data is aggregated, trended and used to identify improvement opportunities. Results are shared with *participating providers* through the CQC, Quality Management Committee, Clinical Advisory Committees, and provider newsletters. Corrective action plans, where appropriate, are managed through the Corporate Provider Relations Department and reported to the CQC.

Changes to ValueOptions Provider Records

Information about *participating providers'* physical addresses and locations, billing addresses, hours of operation, clinical specialties, and licensure or certification status is used in credentialing and re-credentialing activities as well in provider directories and listings made available to clients and *members*. *Participating providers* must notify ValueOptions in writing and in advance of changes or updates to information provided to ValueOptions.

Changes and updates to *participating provider* information and records may be submitted to ValueOptions via mail or facsimile to the address or facsimile number noted below and using the ValueOptions Change of Address form or W-9 Substitute form accessible through the [website](#).

At the time of re-credentialing, *participating providers* may make changes to information previously submitted to ValueOptions and contained in their ValueOptions Provider Record through ProviderConnect.

Failure to report changes in a timely manner can adversely affect participation in the network and may result in claims payments being delayed.

ValueOptions, Inc.
c/o Practitioner Maintenance
P.O Box 41055
Norfolk, VA 23541
OR
Fax: (866) 612-7795

Policies & Procedures

Pursuant to the terms of the *provider agreement*, *participating providers* must comply with ValueOptions' *policies and procedures* and as outlined in this *handbook*. Certain *policies and procedures* may apply only to a designated line of business or type of benefit plan or government sponsored health benefit program; a list of these is located in [Appendix 3](#).

The *CMS* requires *Medicare Advantage* plans to include certain terms and provisions in *provider agreements* and in *policies and procedures*. [Appendix 4](#) includes references to specific regulatory requirements and guidelines about participation in networks available to *Medicare Advantage* plans.

As more specifically detailed in other parts of this handbook, ValueOptions maintains continuous quality improvement and utilization management programs that include *policies and procedures* and measures designed to provide for ongoing monitoring and evaluation of services rendered to *members* (e.g., clinical review criteria, controlled studies, *member* and *participating provider* surveys, evaluations and audits). *Participating provider* involvement is an integral part of these programs. *Participating providers* must cooperate with and participate in ValueOptions' quality improvement and utilization management programs and activities. Refusal to cooperate with ValueOptions' quality improvement and/or utilization management activities may adversely affect continued network participation status or result in sanctions up to and including termination of network participation status.

In addition, some ValueOptions clients establish procedures and requirements unique to benefit plans offered or administered by that client or to a specific government health benefit program. Therefore, in addition to careful review of the information provided in this *handbook*, it is very important to review any client and/or network specific requirements located in the 'Provider' section of the *website*.

Detailed information about a specific *member's* benefit plan requirements can also be obtained by calling the toll-free number on the *member's* identification card or by viewing a *member's* benefits on the 'Benefit' tab in *ProviderConnect*.

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Credentialing & Re-Credentialing

ValueOptions' credentialing processes for new *providers* seeking to contract with ValueOptions and re-credentialing processes for *participating providers* currently contracted with ValueOptions is designed to comply with national accreditation standards to which ValueOptions is or may be subject, as well as applicable state and/or federal laws, rules and regulations. Credentialing and re-credentialing is required for all *providers* and *participating providers*, respectively, including without limitation individual practitioners and organizations (clinics, facilities or programs). All *provider/participating provider* office or facility locations where services are rendered and that share the same federal tax identification number that are identified in credentialing/re-credentialing applications will be considered for participation status under that application.

Providers and *participating providers* are credentialed and re-credentialed, respectively, for participation status for designated services and/or level(s) of services. Should *participating providers* have other or additional services or levels of services available, additional credentialing and/or re-credentialing may be necessary prior to designation as a '*participating provider*' for such additional services and/or levels of services. Services and/or levels of services for which a *participating provider* is not credentialed are subject to all applicable out-of-network authorization, certification and any benefit or coverage limitations under the *member's* benefit plan.

As provided for in ValueOptions' *policies and procedures*, decisions to approve or decline initial credentialing applications, to approve re-credentialing applications and/or to submit a given credentialing or re-credentialing application for further review are made by ValueOptions National Credentialing Committee (NCC), or where applicable by a local ValueOptions' established credentialing committee.

Participating providers have the right to: (a) request review information submitted in support of credentialing or re-credentialing applications; (b) correct erroneous information collected during the credentialing or re-credentialing processes; (c) request information about the status of credentialing or re-credentialing applications. All requests to review information must be submitted in writing. Verbal requests for the status of a credentialing or re-credentialing application can be made by calling the National Network Provider Line at (800) 397-1630, Monday through Friday, 8 a.m. to 5 p.m. EST. Regardless of the above, ValueOptions will not release information obtained through the primary source verification process where prohibited by applicable state and/or federal laws, rules and/or regulations.

Credentialing

Initial credentialing processes begin with submission of completed and signed applications, along with all required supporting documentation. This includes without limitation attestation as to: (a) any limits on the *provider's* ability to perform essential functions of their position or operational status; (b) with respect to individual practitioner *providers*, the absence of any current illegal substance or drug use; (c) any loss of required state licensure and/or certification; (d) absence of felony convictions; (e) with respect to individual practitioner *providers*, any loss or limitation of privileges or disciplinary action; and (f) the correctness and completeness of the application.

Failure of a *provider* to submit a complete and signed credentialing application, and all required supporting documentation timely and as provided for in the credentialing application and/or requests from ValueOptions, may result in rejection of request for participation status with ValueOptions.

Re-Credentialing

Re-credentialing for *participating providers* is required every three (3) years, or such shorter period of time where required by a specific state law or regulation. The process for re-credentialing begins approximately six (6) months prior to the end of the initial credentialing cycle or the preceding re-credentialing cycle, as applicable, with the mailing of a re-credentialing application via USPS to the *participating provider* or notification by ValueOptions to the *participating provider* via email, voicemail or facsimile that their online re-credentialing application is available via ProviderConnect. Required documentation includes without limitation attestation as to: (a) any limits on the *participating provider's* ability

to perform essential functions of their position or operational status; (b) with respect to individual practitioner *participating providers*, the absence of any current illegal substance or drug use; and (c) the correctness and completeness of the application (including without limitation identification of any changes in or updates to information submitted during initial credentialing).

Failure of a *participating provider* to submit a complete and signed re-credentialing application, and all required supporting documentation timely and as provided for in the re-credentialing application and/or requests from ValueOptions, may result in termination of participation status with ValueOptions and such *providers* may be required to go through the initial credentialing process.

Standards

Standards applicable to *providers* in the initial credentialing process and to *participating providers* in the re-credentialing process include, but are not limited to the following:

- Current, unencumbered (not subject to probation, suspension, supervision and/or other monitoring requirements) and valid license to practice as an independent provider at the highest level certified or approved by the state or states in which services are performed for the *provider's/participating provider's* specialty (individual practitioners)
- Current, unencumbered (not subject to probation, suspension, supervision and/or other monitoring requirements) and valid license to practice and/or operate independently at the highest level certified or approved by the state or states in which services are performed for the *provider's/participating provider's* facility/program status (organizations)
- Accreditation accepted by ValueOptions (currently TJC, CARF, COA, HFAP, AAAHC, NIAHO, CHAP and AOA) (organizations*)
- Clinical privileges in good standing at the institution designated as the primary admitting facility, with no limitations placed on the ability to independently practice in his/her specialty (individual practitioners)
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline or licensure (individual practitioners)
- Current specialty board certification, if indicated on the application (individual practitioners)
- A copy of a current Drug Enforcement Agency (DEA) certificate, and/or Controlled Dangerous Substance (CDS) Certificate where applicable (individual practitioners)
- No adverse professional liability claims which result in settlements or judgments paid by or on behalf of the *provider/participating provider* which disclose an instance of, or pattern of, behavior which may endanger *members*
- Good standing with state and federal authorities and programs (organizations)
- No exclusion or sanctions from government sponsored health benefit programs (e.g., Medicare/Medicaid) (individual practitioners and organizations)
- Current specialized training as required for certain levels or areas of specialty care (individual practitioners)
- Malpractice and/or professional liability coverage in amounts consistent with ValueOptions *policies and procedures* (individual practitioners and organizations)
- An appropriate work history for the *provider's/participating provider's* specialty (individual practitioners)

* Structured site visits are required for all unaccredited organizations.

Changes or updates to any of the above noted information is subject to re-verification from primary sources during the re-credentialing process, or at the time of notice of such a change or update from the *participating provider*.

- No adverse record of failure to follow ValueOptions' *policies and procedures* or Quality Management activities.
- No adverse record of provider actions that violate the terms of the *provider agreement*
- No adverse record of indictment, arrest or conviction of any felony or any crime indicating potential or actual *member* endangerment

- No criminal charges filed relating to the *participating provider's* ability to render services to *members*
- No action or inaction taken by *participating provider* that, in sole discretion of ValueOptions results or may result in a threat to the health or well-being of a *member* or is not in the *member's* best interest

Site Visits

In addition and as part of credentialing or re-credentialing, ValueOptions may conduct a structured site visit of *provider's/participating provider's* offices/locations. Site visits include, but may not be limited to, an evaluation using the ValueOptions site and operations standards and an evaluation of clinical recordkeeping practices against ValueOptions standards.

The current ValueOptions site visit tool is available for review on the *website*. As the site visit tool is subject to modification without notice, *participating providers* are encouraged to check the *website* for the most current site visit tool prior to scheduled site visits. While ValueOptions, in its discretion, may require a site visit in the course of credentialing and/or re-credentialing processes based on information submitted and/or obtained in the process, site visits will be conducted for *providers/participating providers* in the following categories: (a) unaccredited organizations; (b) site visits required by a ValueOptions client as part of credentialing/re-credentialing activities delegated to ValueOptions; (c) *providers/participating providers* with two or more documented *member* complaints in a six (6) month time frame relating to physical accessibility, physical appearance, adequacy of waiting/examining room space, or alleged quality of care issues.

Site visits are arranged in advance. Following the site visit, ValueOptions will provide a written report detailing the findings, which report may include required monitoring where applicable and/or requirements for the *participating provider* to submit an action plan.

Updates

Providers/participating providers are required to report material changes to information included in credentialing and/or re-credentialing applications submitted to ValueOptions. Except as noted below, all such changes must be reported in writing within the time period provided for in the provider agreement, but not to exceed ten (10) calendar days of the *provider/participating provider* becoming aware of the information. Failure to comply may result in immediate termination of network participation status. The following is a list (This is not an exhaustive list.) of examples of the types of material changes for which the above report is required:

- Any action against licenses, certifications, registrations, and/or accreditation status*
- Any legal or government action initiated that could materially affect the rendering of services to *members*
- Any legal action commenced by or on behalf of a *member*
- Any initiation of bankruptcy or insolvency proceedings, whether voluntary or involuntary
- Any other occurrence that could materially affect the rendering of services to *members*
- Discovery that a claim, suit or criminal or administrative proceeding is being brought against the *provider/participating provider* relating to the provider's malpractice, compliance with community standards and applicable laws, including any action by licensing or accreditation entities and/or exclusions from a government sponsored health benefit program (e.g., Medicare/Medicaid)

* The suspension, revocation, expiration and/or voluntary surrender of professional license/certification, DEA certificate, CDS certificate, and/or board certification must be reported within five (5) calendar days of the effective date of the action. (Contact ValueOptions to coordinate the transition of *members* to the care of other *participating providers* where licensure/certification no longer meets ValueOptions credentialing/re-credentialing standards and/or requirements pursuant to state and/or federal laws regarding the provision of services.)

Note: If a *participating provider* moves to or expands their practice and/or operations into another state, a copy of the *participating provider's* license/certification and malpractice/professional liability coverage is required in order to complete primary source verification.

Expiration, non-renewal and/or decrease in required malpractice or professional liability coverage must be reported thirty (30) days prior to such change in coverage.

Any changes in demographic information or changes in practice patterns such as change of services and/or billing address, name change, coverage arrangements, tax identification number, hours of operation, and/or changes in ownership must be provided to ValueOptions in advance of such changes.

Changes in ownership and/or management of *participating providers* may require negotiation and execution of consent to assignment and assumption agreements as related to *provider agreements* and the parties to provider agreements.

Delegation

Should ValueOptions, in its sole discretion, elect to consider delegation of any credentialing and/or re-credentialing activities to a *participating provider*, such delegation is subject to all applicable *policies and procedures*, state and federal laws, rules and/or regulations, accreditation standards to which ValueOptions is or may be subject, and any client and/or government program specific requirements. Reference to possible delegation herein in no way obligates or requires ValueOptions to consider delegation of any credentialing and/or re-credentialing activities.

Sanctions

While efforts are made to resolve *provider/participating provider* credentialing/re-credentialing issues and/or quality issues through consultation and education, occasionally further action is necessary to provide for quality service delivery and protection of *members*. Sanctions may be imposed for issues related to *member* complaints/grievances, credentialing/re-credentialing issues, professional competency and/or conduct issues, quality of care concerns/issues, and/or violations of state and/or federal laws, rules and/or regulations. ValueOptions processes comply with all applicable local, state and/or federal reporting requirements regarding professional competence and/or conduct. Subject to modification based on the facts and circumstances in a given case, the following is a list of possible sanctions that may be imposed on *participating providers* by the ValueOptions National Credentialing Committee (NCC), any ValueOptions local credentialing committee, and/or the ValueOptions Provider Appeals Committee (PAC). The descriptions below are not in any specific order and should not be interpreted to mean that there is a series of sanctions; any one or more possible sanctions described below may be imposed in any order or sequence.

Type	Definition
Consultation	A call is placed to notify the <i>participating provider</i> of the alleged action or incident. The <i>participating provider</i> will be provided with an explanation of possible sanctions if corrective actions are not taken. The call will be documented to include the date and subject for consultation. A copy of the consultation will be placed in the <i>participating provider's</i> file. Appropriate educational materials will be sent via certified mail.
Written Warning	A written notice is sent to the <i>participating provider</i> notifying him/her of the alleged action or incident. Possible sanctions, if corrective actions are not taken, will be explained. A copy of the letter is retained in the <i>participating provider's</i> file; educational material is sent via certified mail. Corrective action will be monitored as necessary.

<p>Second Warning/ Monitoring</p>	<p>At the discretion of the Medical Director, a second written notice may be sent to the <i>participating provider</i> and a copy of such letter shall remain in the <i>participating provider's</i> file. Additionally, the <i>participating provider</i> may be placed on monitoring when data indicates nonconformance with standards; and, if ValueOptions determines it is in the <i>members'</i> best interest, ValueOptions may elect to suspend new <i>member</i> referrals, new <i>member</i> authorizations and/or redirect all current <i>members</i> to other <i>participating providers</i>. The <i>participating provider</i> will be given written notice (and where applicable notice of fair hearing rights) via facsimile and certified mail of the issues for which the <i>participating provider</i> is being suspended. A copy of the letter is placed in the <i>participating provider's</i> file.</p> <p><u>Facility/Program Participating Providers:</u> An action plan will be provided consisting of steps that, when taken, will remedy the deficiencies or concerns that created the need for monitoring. The <i>participating provider</i> is expected to make a best effort to comply with the monitoring action plan. If an action plan has been sent, the <i>participating provider</i> is expected to notify ValueOptions in writing of the status of the issue for which monitoring was initiated at the end of the action plan timeline, or sooner if applicable. The <i>participating provider</i> is expected to keep ValueOptions updated in writing of all changes in the issue/concern that triggered monitoring.</p>
<p>Suspension</p>	<p>The <i>participating provider</i> may be suspended from network participation pending resolution of issues raised. Suspension requires NCC action. During suspension, ValueOptions may elect to suspend new <i>member</i> referrals, new <i>member</i> authorizations and/or redirect all current <i>members</i> to other <i>participating providers</i>. The <i>participating provider</i> will be given written notice via facsimile and certified mail of the issues for which it is being suspended. A copy of the letter is placed in the <i>participating provider's</i> file. The suspension may last for a period of 30 calendar days during which time an investigation may take place. The NCC may extend this time period as necessary to gather additional information.</p> <p><u>Individual Participating Providers:</u> The suspension may last for a period of up to thirty (30) calendar days during which time an investigation may take place. The NCC may extend this time period as necessary to gather additional information.</p>
<p>Termination</p>	<p>The <i>participating provider</i> may be terminated from the network. Termination requires NCC action. The <i>participating provider</i> will be given written notice via facsimile and certified mail that the <i>participating provider</i> is being terminated from the network and the reason for the termination. A copy of the letter is put in the <i>participating provider's</i> file. <i>Members</i> in care will be notified and given assistance for referral to a new <i>participating provider</i> for continuing care, as necessary.</p>

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***Appeals* of National Credentialing Committee (NCC)/Provider *Appeals* Committee (PAC) Decisions**

The ValueOptions National Credentialing Committee (NCC) and ValueOptions local credentialing committees will give *providers/participating providers* written notice of the committee's decision regarding credentialing or re-credentialing applications submitted, any sanctions imposed or recommended, the reason for the decision, and of the *provider's/participating provider's* right to *appeal* adverse decisions along with an explanation of the applicable *appeals* procedure(s). Unless otherwise identified in such written notice, *providers/participating providers* have thirty (30) calendar days from the date of the committee's notice of an adverse decision to file a written request for an *appeal*.

Provider/participating provider appeals of adverse credentialing/re-credentialing decisions of a ValueOptions local credentialing committee may be appealed to the NCC.

The NCC: (a) functions as a peer review body under *NCQA* standards; (b) is made up of representatives from major clinical disciplines and includes *participating providers*; and (c) makes the final decision regarding: (i) ValueOptions credentialing/re-credentialing *policies and procedures*, (ii) approval/denial/pending status for credentialing/re-credentialing applications, and (iii) determinations regarding possible *participating provider* sanctions identified above.

Provider/participating provider appeals of adverse credentialing/re-credentialing decisions of the NCC may be appealed to the ValueOptions Provider Appeals Committee (PAC*).

Requests for *appeals* of adverse credentialing/re-credentialing decisions of the NCC should include an explanation of the reasons the *provider/participating provider* believes the NCC reached a decision to be in error and include supporting documentation. The PAC will review the explanation provided, the information previously reviewed by the NCC, and any additional information determined to be relevant. The PAC may request additional information from the *provider/participating provider* in order to make a determination or decision. The PAC will support, modify, or overturn the decision of the NCC. Written notification of the PAC's decision, an explanation of the decision, and any *appeal* and/or fair hearing rights available for adverse decisions, will be sent to the *provider/participating provider* within fourteen (14) business days after the PAC's record is complete.

* The PAC is comprised of representatives of major clinical disciplines, *participating providers* and clinical representatives from corporate departments within ValueOptions, none of whom have participated in the original NCC adverse decision under review.

Professional Review Activities/Fair Hearing Process

Individual *providers/participating providers* may request a second level of *appeal/a fair hearing* when the PAC denies credentialing, re-credentialing, issues a sanction or recommends termination of participation status of a *provider* from the ValueOptions provider network based on quality of care issues and/or issues related to professional competence or professional conduct.

Included in written notification of a PAC adverse decision based on quality of care issues and/or issues related to professional competency or professional conduct, will be an explanation of the decision, *fair hearing* rights available to the *provider/participating provider*, an explanation of *fair hearing* procedures, and a list of witnesses, if identified at this time, expected to testify and/or present information on behalf of ValueOptions.

Requests for a *fair hearing* must be submitted to ValueOptions within thirty (30) calendar days of the date of the PAC notification of adverse decision to the *provider/participating provider*. While ValueOptions will make reasonable efforts to coordinate the date and time of *fair hearings* requested with the involved *provider/participating provider*, should ValueOptions and the involved *provider/participating provider* be unable to come to agreement on the date and time of the requested *fair hearing* ValueOptions will identify the date, time and location for the *fair hearing*, which date shall be within the ninety (90) calendar day period following request for the *fair hearing*.

The chair of the PAC will identify peer reviewers who will participate as the *fair hearing* panel. Every effort will be made to include a representative of the discipline of the *provider/participating provider* requesting the *fair hearing* on the panel. Members of the *fair hearing* panel will not have participated in the prior adverse decisions of the PAC or NCC, and will be asked to represent the lack of any economic interest adverse to the *provider/participating provider*. One member of the *fair hearing* panel will be selected to act as the hearing officer and will preside over the *fair hearing*.

ValueOptions and the *provider/participating provider* each have the right to legal representation at the *fair hearing*. The *provider/participating provider* will receive the written recommendation from the panel within fifteen (15) business days after the *fair hearing*. The *fair hearing* process as set forth above is subject to applicable state and/or federal laws and/or regulations.

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Office Procedures

Member Rights & Responsibilities

ValueOptions' *Member Rights and Responsibilities Statement* is available in English and Spanish for download from the *website*. *Participating providers* are encouraged to post the Statement in their offices or waiting rooms or distribute the Statement to *members* at their initial visit.

Access to Treatment Records & Treatment Record Reviews/Audits

ValueOptions may request access to and/or copies of *member* treatment records and/or conduct *member* treatment record reviews and/or audits: (a) on a random basis as part of continuous quality improvement and/or monitoring activities; (b) as part of routine quality and/or billing audits; (c) as may be required by clients of ValueOptions; (d) in the course of performance under a given client contract; (e) as may be required by a given government or regulatory agency; (f) as part of periodic reviews conducted pursuant to accreditation requirements to which ValueOptions is or may be subject; (g) in response to an identified or alleged specific quality of care, professional competency or professional conduct issue or concern; (h) as may be required by state and/or federal laws, rules and/or regulations; (i) in the course of claims reviews and/or audits; and/or (j) as may be necessary to verify compliance with the *provider agreement*.

ValueOptions treatment record standards and guidelines for *member* treatment record reviews conducted as part of quality management activities are set out in the quality management section of this *handbook*.

Unless otherwise specifically provided for in the *provider agreement*, access to and any copies of *member* treatment records requested by ValueOptions or designees of ValueOptions shall be at no cost.

Participating providers will grant access for *members* to the *member's* treatment records upon written request and with appropriate identification. *Participating providers* should review *member* treatment records prior to granting access to *members* to ensure that confidential information about other family members and/or significant others that may be referenced and/or included therein is redacted.

Confidentiality, Privacy & Security of Identifiable Health Information

Providers/participating providers are: (a) expected to comply with applicable federal and state privacy, confidentiality and security laws, rules and/or regulations, including without limitation the federal Health Information Portability and Accountability Act of 1996 and the rules and regulations promulgated thereunder, and 42 C.F.R. Part 2; and (b) are responsible for meeting their obligations under these laws, rules and regulations, by implementing such activities as monitoring changes in the laws, implementing appropriate mitigation and corrective actions, and timely distribution of notices to patients(*members*), government agencies and the media when applicable. In the event that ValueOptions

receives a complaint or becomes aware of a potential violation or breach of an obligation to secure or protect *member* information, ValueOptions will notify the *provider/participating provider* utilizing the general complaint process, and request that the *provider/participating provider* respond to the allegation and implement corrective action when appropriate. *Participating providers* must respond to such requests and implement corrective action as indicated in communications from ValueOptions.

Providers/participating providers and their business associates interacting with ValueOptions staff should make every effort to keep protected health information secure. If *provider/participating provider* does not use email encryption, ValueOptions recommends sending *protected health information* to ValueOptions through an inquiry in ProviderConnect or by secure fax.

Appointment and Availability Standards

Participating providers are expected to maintain established office/service hours and access to appointments with standards established by ValueOptions and/or as may be required by a given client of ValueOptions and/or specific government sponsored health benefit program.

Except as otherwise required by a specific client and/or government sponsored health benefit program for *providers* participating in networks available to their respective *members* and/or as delineated in the *provider agreement*, the following are standards of availability for appointments for which *participating providers* are required to maintain:

Emergency: In an *emergency* situation, the *member* should be seen in person immediately or referred to appropriate *emergency service providers*. *Participating providers* who do not maintain twenty-four (24) hour coverage must maintain a system for referring *members* to a source of *emergency* assistance during non-business hours. The preferred methods are through a live answering service or an on-call pager system. However, *participating providers* may elect to maintain a reliable recorded answering machine system through *members* experiencing an *emergency* are given clear instructions about how to access immediate assistance after hours.

Emergent: In an *emergent* situation, the *member* should be seen within six (6) hours of the request for an appointment or referred to appropriate *emergency service providers*.

Urgent: In an *urgent* situation, the *member* must be offered the opportunity to be seen within forty-eight (48) hours of a request for an appointment.

Routine: In a *routine* situation, a *member* must be offered the opportunity to be seen within 14 calendar days or 10 business days of a request for an appointment.

Out-of-Office Coverage

Participating providers should: (a) contact ValueOptions Customer Service at (800) 397-1630 during normal business hours Monday through Friday, 8 a.m. to 5 p.m. EST to inform ValueOptions of any unavailability or absence; and (b) notify ValueOptions National Network Operations at the address below in writing of coverage arrangements in advance of vacation, sabbatical, illness, maternity leave(where applicable), and/or any other situation when *participating provider* is unable to continue to treat ValueOptions *members* in active treatment. Such advance written notice should include: *participating provider's* name, licensure, practice locations affected, the reason for unavailability or absence and date range of unavailability or absence. Upon receipt of such advance notice, the *participating provider's* status in ValueOptions' systems is changed to 'inactive'.

Mail to: ValueOptions, Inc.
P.O Box 41055
Norfolk, VA 23541

OR

Fax to: (866) 612-7795

Upon return, *participating providers* should contact ValueOptions Customer Service at (800) 397-1630 Monday through Friday, 8 a.m. to 5 p.m. EST and should notify ValueOptions National Network Operations at the address above in writing. Failure to contact ValueOptions within thirty (30) days of return may result in referral, utilization management and claims processing delays due to the 'inactive' status placed in ValueOptions' systems. Failure to respond to communications from ValueOptions related to 'inactive' or out-of-office versus 'active' status in ValueOptions' systems within the time period provided for in such communications may result in termination of participation in ValueOptions' provider networks.

Requests for Additional Information

To maintain in-network status, *participating providers* must furnish ValueOptions with any requested documentation or information promptly. Failure to do so may result in the *participating provider's* status being changed from active to inactive. Inactive providers are ineligible to receive referrals or reimbursement as *participating providers* for services rendered to *members* of ValueOptions' clients and/or *payors*.

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Services to *Members*

Pursuant to the terms of the *provider agreement*, *participating providers* are contracted and credentialed to provide identified *covered services* to *members*. *Covered services* should be rendered in: (a) the same manner as services rendered to other patients; (b) accordance with accepted medical standards and all applicable state and/or federal laws, rules and/or regulations; and (c) a quality and cost-effective manner. *Participating providers* should note that coverage for behavioral health services and any limitations and/or exclusions as well any *pre-authorization* and/or *certification* requirements for non-emergency services vary by benefit plan.

Participating providers must:

- Verify *member* eligibility and benefits using telephonic and/or on-line processes made available by ValueOptions prior to rendering non-emergency services;
- Document other or third party health benefit coverage for *members* (Claims should be submitted to the primary payer initially.);
- *Preauthorize* or *certify* care where required in ValueOptions *policies and procedures* or the applicable *member* benefit plan, prior to rendering non-emergency services;
- Collect *member expenses* from the *member* prior to, at the time of, or subsequent to services being rendered;
- Provide continuous care for *members* or arrange for on-call coverage by other ValueOptions *participating providers*;
- Adhere to the accessibility and availability standards established by ValueOptions;
- Provide equal treatment to patients in a non-discriminatory manor, regardless of source of payment or coverage type or product;
- Update demographic, office and/or *participating provider* profile information promptly and in advance of changes;
- Notify ValueOptions of potential inpatient discharge problems;
- Advise *members* in writing of financial responsibility regarding services that are not covered, prior to rendering such service;
- Notify ValueOptions of *members* who may be candidates for potential Care Management;
- Coordinate care with a *member's* other health/medical care provider(s), either behavioral and/or medical providers who are treating the same or related (co-morbid) conditions;
- Refer *members* to other *participating providers* when alternative or different mental health or substance abuse services are required;
- Submit claims on behalf of *members*; and
- Upon written request by ValueOptions or third party payers, submit copies of *member* treatment records without charge (unless otherwise expressly provided for in the *provider agreement*).

Emergency Services

In the event of an *emergency* admission, *participating providers* should notify ValueOptions as soon as reasonably practicable and in any event with one (1) calendar day, or within such alternative period of time specified in the *provider agreement*, of the date of admission. Retrospective review of such admissions and associated services is subject to the terms of the *member's* benefit plan.

Referrals

Participating providers may receive referrals from several sources: (a) from *providers* and/or other *participating providers*; (b) through self-referral of *members*; (c) from ValueOptions; and/or (d) through an *EAP*.

Participating providers needing to refer a *member* for other or additional services should contact ValueOptions to identify what are *covered services* under the *member's* benefit plan and any limitations, exclusions and/or notice, *pre-authorization* or *certification* or *notification* requirements under their benefit plan.

EAP Transition to Health Plan Benefits

For those *members* participating in an EAP administered by ValueOptions and who may schedule and/or be referred for appointments for behavioral health services under their benefit plan, *participating providers* must be sure to obtain *pre-authorization* or *certification* as may be required under the *member's* benefit plan. Questions regarding what are *covered services* under the *member's* benefit plan and associated *member expenses* for *covered services* should be directed to ValueOptions by calling the number of the back of the *member's* identification card.

On Track Outcomes

The ValueOptions *On Track Outcomes* Program is an ongoing initiative designed to assist *participating providers* incorporate *member-reported* feedback into outpatient psychotherapy sessions with the intended goal of improving outcomes. *On Track* supports *participating providers* as they help *members* stay “on track” in achieving their goals. This program is based on the completion of the Client Feedback Form (CFF) by the *member* during the course of receiving psychotherapy services. Participation by *members* is voluntary.

The CFF is designed to help *participating providers* assess clinical risk and monitor changes in symptoms and functioning as *members* receive services. *Participating providers* are asked to administer the CFF to *members* prior to the first, third, and every third session thereafter. The completed CFF should be reviewed by the *participating provider* and faxed to the designated toll-free *On Track* facsimile number for analysis. Scored and analyzed results generally are available online within one (1) business day. *On Track* provides *member-specific* tracking of progress in comparison to normative benchmarks, uses predictive modeling to identify potential high risk cases, and generates reports on aggregate case-mix adjusted provider outcomes. ValueOptions clinical staff may conduct outreach calls on particularly high risk cases.

Participating providers begin the *On Track* Program by registering online at www.psychoutcomes.org/ValueOptions, a website operated by a ValueOptions business partner. *Participating providers* who are logged into ProviderConnect can connect directly to their *On Track* tools by using the link under ‘Clinical Support Tools’. A separate *On Track* user ID and password are not needed. A personal, secure web page is available for each *participating provider* to view CFF results for *members* under their care. Detailed information about the *On Track* program, personalized copies of the CFF, and information for *members* can also be accessed here.

Coordination with Primary Care/Treating Providers

As part of care coordination activities, *participating providers* should identify all *providers/participating providers* involved in the medical and/or behavioral health care and treatment of a *member*. Subject to any required consent or authorization

from the *member*, *participating providers* should coordinate the delivery of care to the *member* with these *providers/participating providers*. ValueOptions consent forms are available through the *website*.

Continuation following *Provider Agreement Expiration or Termination*

Non-renewal and termination of the *provider agreement* is the process by which the *provider agreement* is not renewed at the end of the identified period of time and accordingly ends by its own terms, or the *provider agreement* is terminated as provided for in the terms of the *provider agreement*.

All notices of non-renewal and/or termination of the *provider agreement* should be in writing and in accordance with the applicable terms of the *provider agreement*.

If a *participating provider* chooses to resign from the network and voluntarily surrender participation status, the *participating provider* must send ValueOptions written notice of such request and/or notice of termination of the *provider agreement* pursuant to the without cause termination provisions of the *provider agreement* (if any). ValueOptions will send the *participating provider* written acknowledgement of receipt of the *participating provider's* written request/notice and confirmation of the effective date of disenrollment/termination consistent with the provisions of the *provider agreement*. *Providers* who resign from network or voluntarily terminate the *provider agreement* are not eligible for re-application for six (6) months following the effective date of disenrollment/termination.

The effective date of non-renewal or termination of the *provider agreement* is that date: (a) identified in the notice of non-renewal or termination of the *provider agreement* and consistent with the end of the specific notice period; or (b) the date mutually agreed upon in writing by the *participating provider* and ValueOptions.

On or before the effective date of non-renewal or any termination of the *provider agreement*, *participating providers* must provide ValueOptions with a list of *members* for whom the *participating provider* has rendered services in the six (6) month period prior to the effective date of non-renewal or any termination of the *provider agreement*.

Participating providers must continue to provide *covered services* to *members* following the non-renewal or termination of the *provider agreement* pursuant to the terms of the *provider agreement* and for such time period(s) as are set out in the *provider agreement*. Payment for such *covered services* rendered to *members* following non-renewal or termination will be at the rates in the *provider agreement*.

Certain Regulatory Requirements

Provider agreements include provisions requiring *participating providers* to comply with all applicable state and/or federal laws, rules and/or regulations, including without limitation those related to the provision of mental health and/or substance abuse services (e.g., required licensure/certification, workplace standards, non-discrimination, etc.), child or elder abuse, and duty to warn or obligation to report certain types of disclosures by patients, and those related to fraud, waste and abuse. It is the responsibility of *providers* and *participating providers* to understand and comply with the professional and legal requirements within the state(s) in which *providers/participating providers* practice and/or render services.

By way of example, the Americans with Disabilities Act of 1990, as amended (ADA) contains provisions regarding services to certain individuals identified as covered under the ADA. *Participating providers* are encouraged to adapt services and their offices/locations to meet the special needs of *members*.

Fraud, Waste and Abuse

ValueOptions interacts with employees, clients, vendors, *providers/participating providers* and *members* using standard clinical and business ethics seeking to establish a culture that promotes the prevention, detection and resolution of possible violations of laws and unethical conduct. In support of this, ValueOptions' compliance and anti-fraud plan was established to prevent and detect fraud, waste or abuse in the behavioral health system through effective

communication, training, review and investigation. The plan, which includes ValueOptions' code of conduct, is intended to be a systematic process aimed at monitoring of operations, subcontractors and *providers/participating providers* compliance with applicable laws, regulations, and contractual obligations. *Participating providers* are required to comply with provisions of ValueOptions' code of conduct where applicable, including without limitation cooperation with claims billing audits, post-payment reviews, benefit plan oversight and monitoring activities, government agency audits and reviews, and participation in training and education. ValueOptions' code of conduct is accessible on the *website*.

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Participating Provider Complaints, Grievances & Appeals

The ValueOptions *complaint, grievance* and *appeal* processes provide an effective method and dependable problem resolution procedure for the informal resolution of *participating provider complaints*, issues, concerns or disputes that may arise related to the credentialing/re-credentialing process, *medical necessity* adverse determinations, administrative denials, claims processing and payment or denial of claims, and otherwise related to the *provider agreement*.

Information about the process for *appeals* related credentialing and/or re-credentialing decisions is set out in the *appeals* section of this *handbook*.

Information about the process for *appeals* of adverse determinations is set out in the *appeals* section of this *handbook*.

Complaints Regarding the Provider Agreement

Initial *participating provider complaints* regarding the terms of the *provider agreement* and/or performance by ValueOptions or the *participating provider* under the *provider agreement* should be submitted in writing to the local ValueOptions Service Center or to ValueOptions Provider Relations Department at the address referenced in the Contacts section of this *handbook* within ten (10) business days of the event that gave rise to the *complaint* or within ten (10) business days from the time the *participating provider* should have reasonably first become aware of the event. Correspondence should include all documentation in support of the *complaint* and should provide, at a minimum: (a) reference to the specific term or provision in the *provider agreement* in dispute (It is helpful if the *participating provider* attaches a copy of the page or pages with the specific term or provision in dispute.); (b) a detailed description of the nature of the *complaint* and what action or inaction allegedly is not consistent with or contrary to provision in the *provider agreement*; and (c) the specific remedy requested for resolution. ValueOptions will review the documentation, investigate the concern and respond in writing to the *participating provider* within thirty (30) business days of receipt of the *complaint* and requested documentation.

If the *participating provider* is not satisfied with the response from ValueOptions to the *participating provider's* initial *complaint* regarding the terms of the *provider agreement* and/or performance by ValueOptions or the *participating provider* under the *provider agreement*, the *participating provider* may file second level *complaint* within ten (10) business days of receipt of ValueOptions' response to the *participating provider's* initial *complaint*, or in the absence of a response to the *participating provider's* initial *complaint*, within fifteen (15) business days of submission of the initial *complaint*, to the local ValueOptions Service Center or ValueOptions Provider Relations Department at the address referenced in the Contacts section of this *handbook*. The written second level complaint must contain, at a minimum, the same information required in the initial *complaint* as well as any additional information pertinent to the *complaint*. ValueOptions will review the documentation, investigate the concern and provide a final written response to the *participating provider* within thirty (30) business days of receipt of the second level *complaint* and requested documentation.

General Complaints and Grievances

Participating provider complaints regarding issues other than those related to the terms of the *provider agreement* and/or performance under the *provider agreement* (e.g. *service complaints, complaints about ValueOptions policies and procedures* or the policies and procedures applicable to a specific client benefit plan or government sponsored health benefit program³) should be directed to the ValueOptions National Provider Services Line at [\(800\) 397-1630](tel:8003971630), Monday through Friday, between 8:00 AM and 5:00 PM EST or in writing to:

ValueOptions, Inc.
Attn: Provider Complaint Department
P.O. Box 41055
Norfolk, VA 23541

ValueOptions will acknowledge receipt of *participating provider complaints* verbally or in writing, and thereafter will investigate and attempt to reach a satisfactory resolution of the *complaint* within thirty (30) calendar days of receipt of the *complaint*. A one-time extension of fifteen (15) calendar days can be taken by ValueOptions when a resolution cannot be reached within the above noted thirty (30) calendar day timeframe and the extension is solely for the benefit of a *member*. ValueOptions will notify the *participating provider* verbally or in writing of the proposed resolution to the *complaint*, along with the procedure for filing a *grievance* should the *participating provider* not be satisfied with the proposed resolution.

If the *participating provider* is not satisfied with the proposed resolution of the *complaint*, the *participating provider* may request a formal grievance⁴, either verbally or in writing, within ninety (90) calendar days of receipt of the ValueOptions proposed resolution to the *complaint*. ValueOptions and/or a ValueOptions committee not involved in review of the initial *complaint* will review *participating provider grievance* requests.

Notice of the *grievance* decision will be issued within thirty (30) calendar days of receipt of the *grievance* request from the *participating provider*. A one-time extension of fifteen (15) calendar days can be taken by ValueOptions when a resolution cannot be reached within the above noted thirty (30) calendar day timeframe and the extension is solely for the benefit of a *member*.

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Claims Procedures

ValueOptions maintains claims processing procedures designed to comply with the requirements of client plans, government sponsored health benefit programs, and applicable state and/or laws, rules and/or regulations.

Member Expenses

Member expenses due from the *member* for *covered services* are determined by the *member's* benefit plan. Information about the amount of *member expenses* due for inpatient, outpatient or *emergency covered services* is generally located on the *member's* identification card. *Participating providers* are encouraged to contact ValueOptions for questions regarding *member expenses*.

³ Questions about the policies or procedures applicable to a specific client benefit plan or government sponsored health benefit program should be directed to the ValueOptions Customer Service Department by calling the number on the *member's* identification card.

⁴ The process for participating provider grievance requests set out in this handbook may be modified to the extent applicable state and/or federal laws or regulations to which ValueOptions is subject require otherwise, or alternative processes are required by a given client or government sponsored health benefit program.

It is the responsibility of the *participating provider* to collect *member expenses* due to the *participating provider* for *covered services* rendered.

Preauthorization, Certification or Notification

Preauthorization, certification or notification requirements vary from plan to plan. *Participating providers* must determine if such requirements exist prior to the provision of non-emergency services to *members*. Information regarding ValueOptions' *policies and procedures on authorization, certification or notification* is located in the utilization management/review section of this *handbook*. *Participating providers* may not bill, charge or seek reimbursement from *members* for services determined not to be *medically necessary*.

Providers/participating providers may verify *member* eligibility, submit and review *authorization/certification* requests, and view *authorizations/certifications* online through ProviderConnect on the *website*.

No Balance Billing

Participating providers may not balance bill *members* for *covered services* rendered. This means that the *participating provider* may not bill, charge or seek reimbursement from the *member* for *covered services* except for applicable *member expenses*, and non-covered services.

Claim Submission

Unless otherwise identified in the *provider agreement*, *participating providers* must file or submit claims within ninety (90) calendar days from the date of service or the date of discharge for inpatient admission, or where applicable from date of determination by the primary payor. Claims after the above noted ninety (90) day time period after the date of service may be denied due to lack of timely filing. Claims must match the *authorization or certification or notification* applicable to *covered services* for which the claim applies to avoid potential delays in processing.

Participating providers should not submit claims in their name for services that were provided by a physician's assistant, nurse practitioner, psychological assistant, intern or another clinician. In facility or program settings, supervising clinicians should not submit claims in their name for services that were provided by a resident, intern or psychological assistant.

Separate claim forms must be submitted for each *member* for whom the *participating provider* bills and it must contain all of the required data elements. Each billing line should be limited to one date of service and one procedure code.

When billing for CPT codes that include timed services in the code description (e.g. 90804; 90805; 90806; 90807; & 90808), the actual time spent must clearly be documented within the *member's* treatment record. This time should be documented indicating a session's start and stop times (e.g., 9:00-9:50).

Claims for *covered services* rendered to *members* should be submitted to the address on the *member's* identification card, or electronically through the use of on-line processes available through ProviderConnect on the 'Provider' section of the *website*. *Participating providers* are encouraged to submit claims electronically through ProviderConnect.

All billings by the *participating provider* are considered final unless adjustments or a request for review is received by ValueOptions within the time period identified in the *provider agreement*, or if no time period is identified in the *provider agreement* within sixty (60) calendar days from the date indicated on the *Explanation of Benefits (EOB)*. Payment for *covered services* is based upon authorization, certification or notification (as applicable), coverage under the *member's* benefit plan and the *member's* eligibility at the time of service.

Note: Client plan or government sponsored health benefit program specific claim submission requirements are located in the 'Provider' section of the *website* under 'Network-Specific'.

Required Claim Elements

Claims for *covered services* rendered to *members* should be submitted using UB-04 or CMS-1500 forms, or their respective electronic equivalent or successor forms, with all applicable fields completed and all elements/information required by ValueOptions included. The following is a list of ValueOptions required claim field elements:

- *Member* name and date of birth
- *Member* identification number
- Date(s) and place of service or purchase
- Services and supplies provided
- *ICD-9* code
- *CPT-4* code (and Revenue Code for UB-04 billing)
- Service address and where applicable pay-to address for billing services
- *Provider/ Participating provider's* name, address and tax identification number
- *Provider/ Participating provider's* National Provider Identifier (NPI)
- Taxonomy Code⁵ (on claims submitted electronically)
- *Provider/ Participating provider's* license number
- *Provider/ Participating provider's* charges
- Other information or attachments that may be mutually agreed upon by the parties in writing

In addition, the claim should be free from defect or impropriety (including lack of required substantiating documentation) or circumstance requiring special treatment that prevents timely payment. If additional information is required, the *participating provider* will forward information reasonably requested for the purpose of consideration and in obtaining necessary information relating to coordination of benefits, subrogation, and verification of coverage and health status.

Guidance on completion of UB-04 and CMS-1500 forms, or their electronic equivalents, is available on the 'Provider' section of the *website*.

The use of scanning by means of Optical Character Recognition (OCR) technology allows for a more automated process of capturing information. The following elements are required to take advantage of this automated process. If the *participating provider* does not follow the guidelines, claims will still be processed; however manual intervention will be required.

- Use machine print
- Use original red claim forms
- Use black ink
- Print claim data within the defined boxes on the claim form
- Use all capital letters
- Use a laser printer for best results
- Use white out or correction tape for corrections
- Submit any notes on 8 ½" x 11" paper
- Use an eight-digit date format (e.g., 10212009)
- Use a fixed width font (Courier, for example)

⁵ The Health Care Provider Taxonomy code set is a collection of unique alphanumeric codes, ten characters in length. The code set is structured into three distinct "levels" including Provider Type, Classification, and Area of Specialization. The Health Care Provider Taxonomy code set allows a single *provider/participating provider* (individual, group, or institution) to identify their specialty category. *Providers/participating providers* may have one or more than one value associated to them.

Requests for Additional Information

To maintain in-network status and upon request by ValueOptions, or its authorized designee, *participating providers* must promptly furnish requested documentation or information related to and/or in support of claims submitted. Failure to do so may result in a change in network participation status from active to inactive. Inactive *providers* are ineligible to receive referrals or payment as a *participating provider* for *covered services* rendered to *members*.

Claim Processing

ValueOptions, or its designee, will process complete and accurate claims submitted by *providers/participating providers* for *covered services* rendered to *members* in accordance with normal claims processing *policies and procedures*, the payment terms included in the *provider agreement*, and applicable state and/or federal laws, rules and/or regulations with respect to timeliness of claims processing.

Normal claims processing procedures may include, without limitation, the used of automated systems which compare claims submitted with diagnosis codes and/or procedure codes and associated billing or revenue codes. Automated systems may include edits that result in an adjustment of the payment to the *provider/participating provider* for *covered services* or in a request for submission of treatment records.

Participating provider agrees that no payment is due for *covered services* or claim submitted unless the *covered services* are clearly and accurately documented in the treatment record prior to submission of the claim.

Payment for services rendered to *members* is impacted by the terms in the *provider agreement*, the *member's* eligibility at the time of the service, whether the services were *covered services*, if the services were *medically necessary*, compliance with any *preauthorization/certification/notification* requirements, *member expenses*, timely submission of the claim, claims processing procedures, overpayment recovery, and/or coordination of benefits activities.

Note: Regardless of any provision to the contrary, *participating providers* acknowledge and agree that the payment rates in the *provider agreement* extend and apply to *covered services* rendered to *members* of benefit plans administered in whole or in part by ValueOptions.

Provider Summary Vouchers

Provider Summary Vouchers (PSVs) or remittance advise are the documents that identify the amount(s) paid and *member expenses* due from the *member*. *Providers/participating providers* may access PSVs through ProviderConnect or request copies of PSVs via facsimile through ValueOptions' automated PSV faxback service at (866) 409-5958. Additional information regarding access to PSVs is available at the 'Provider' section on the *website*.

Coordination of Benefits

Some *members* may have health benefits coverage from more than one source. In these instances benefit coverage is coordinated between primary and secondary payers.

Participating providers should obtain information from *members* as to whether the *member* has health benefits coverage from more than one source, and if so provide this information to ValueOptions.

Coordination of benefits amongst different sources of coverage (payers) is governed by the terms of the *member's* benefit plan and applicable state and/or federal laws, rules and/or regulations. To the extent not otherwise required by applicable laws or regulations, *participating providers* agree that in no event will payment from primary and secondary payers for *covered services* rendered to *members* exceed the rate specified in the provider agreement.

Participating providers must submit a copy of the EOB that includes the primary payer's determination when submitted claims to ValueOptions. The services included in the claim submitted to ValueOptions should match the services included in the primary payer EOB.

Authorization, certification or notification requirements under the *member's* benefit plan still apply in coordination of benefits situations.

Note: Some benefit plans require that the *member* update at designated time periods (e.g., annually) other health benefit coverage. Claims may be denied in the event the *member* fails to provide the required other coverage updates.

Overpayment Recovery

Participating providers should routinely review claims and payments in an effort to determine if the *participating provider* has received any overpayments. ValueOptions will notify *providers* and *participating providers* of overpayments identified by ValueOptions, clients and/or government agencies, and/or their respective designees. Overpayments include, but are not limited to: (a) claims paid in error; (b) claims allowed/paid greater than billed; (c) inpatient claim charges equal the allowed amounts; (d) duplicate payments; (e) payments made for individuals whose benefit coverage is or was terminated; (f) payments made for services in excess of applicable benefit limitations; and (g) payments made in excess of amounts due in instances of third party liability and/or coordination of benefits.

Subject to the terms of the *provider agreement* and applicable state and/or federal laws and/or regulations, ValueOptions or its designee will pursue recovery of overpayments through: (i) adjustment of the claim or claims in question creating a negative balance reflected on the Provider Summary Voucher (PSV) (claims remittance); and/or (ii) written notice of and request for repayment of the identified overpayment. Failure to respond to any written notice of and/or request for repayment of identified overpayments in the time period identified in the notice/request is deemed approval and agreement with the overpayment; thereafter ValueOptions will adjust the claim or claims in question creating a negative balance. Any negative balance created will be offset against future claims payments until the negative balance is zeroed out and the full amount of the overpayment is recovered. ValueOptions may use automated processes for claims adjustments in the overpayment recovery process.

In those instances in which there is an outstanding negative balance as a result of claims adjustments for overpayments for more than ninety (90) calendar days, ValueOptions reserves the right to issue a demand for repayment. Should a *provider/participating provider* fail to respond and/or provide amounts demanded within the thirty (30) calendar days of the date of the demand letter, ValueOptions will pursue all available legal and equitable remedies, including without limitation placing the outstanding overpayment amount (negative balance) into collections.

If the *provider/participating provider* disagrees with an overpayment recovery and/or request for re-payment of an overpayment, the *provider/participating provider* may request review to ValueOptions in writing such that the written request for review is received by ValueOptions on or before the date identified in notice of overpayment recovery or request for re-payment of an overpayment. Please attach a copy of your written demand or request letter to your request for review and include the following information; *provider/participating provider's* name, identification number and contact information, *member* name, and number, a clear identification of the disputed items to include the date of service and the reason the disputed overpayments are being contested.

Requests for Review

Participating providers may request review of a ValueOptions claims determination. All requests for review must be submitted in writing or made telephonically to address and/or telephone number on the *member's* identification card within sixty (60) calendar days or the time period specified in the *provider agreement* (if any) of the date of the ValueOptions' original claim determination.

Requests for review received beyond the above noted time period will not be reviewed and are considered 'expired'.

Claims Disputes

Participating providers must exhaust all administrative processes prior to pursuant of any further legal or equitable action of unresolved claims disputes pursuant to the terms of the *provider agreement* and more specifically any dispute resolution provisions.

Claims Billing Audits

The ValueOptions Special Investigations Unit (SIU) reviews and monitors claims and billing practices of *providers/participating providers* in response to questions raised, complaints filed and/or issues identified and submitted to the SIU. Questions regarding claims, billing practices or issues identified as a result of internal reviews and audits may be referred to the SIU for review and investigation from a variety of sources, including without limitation: (a) *member* inquiry or complaint; (b) external referral from state, federal and other regulatory agencies; (c) internal staff inquiry, (d) data analysis of certain statistical anomalies; and/or (e) whistleblowers.

The SIU conducts the majority of audits through record review audits, but in some instances on-site audits are performed as well. Record review audits entail requesting an initial sample⁶ of records from the *provider/participating provider* to compare against claims submission records. If a conclusion cannot be determined based on the initial sample of records, ValueOptions may request additional records up to and including records of all *members* for the date span of the audit.

Providers/participating providers must supply copies of requested documents, treatment records, and current and past staff rosters to ValueOptions within the time notated, which is typically ten (10) days, however; the time period for supplying the documents and records may vary based on the number of records requested. For purposes of SIU conducted claims billing audits, the ‘treatment record’ includes progress notes, medication prescription and monitoring records, documentation of counseling sessions, the modalities and frequency of treatment furnished, results of clinical tests, summaries of the following items: diagnoses, functional status, the treatment plan, symptoms, prognosis, and progress to date for the audit period requested. ValueOptions will not reimburse *providers/participating providers* for copies of documents and/or treatment records requested in the course of a claims billing audit, unless otherwise specifically required by applicable state and/or federal law, rule and/or regulation.

In the course of the claims billing audit, documents and records provided are compared against the claims submitted by the *provider/participating provider*. Claims must be supported by adequate documentation of the treatment and services rendered. *Participating providers’* strict adherence to these guidelines is required. A *member’s* treatment record must include the following core elements: *member* name, date of service, rendering *provider* signature and/or rendering *provider* name and credentials, diagnosis code, start and stop times; 9:00 to 9:50 and service code to substantiate the billed services. The lack of proper documentation for services rendered could result in denial of payment, or, if payment has already been issued a request for refund from the SIU.

The SIU coordinates claims billing audits with appropriate ValueOptions clinical representatives where necessary. Following completion of review of the documents and records, the SIU will provide a written report of the findings. In some instances, such report of the findings may include a request for additional records. Once the written report of findings is issued, ValueOptions will not accept additional or missing documentation associated with any identified billing errors.

In the event that improper or unsubstantiated billings are identified by the SIU, the report of findings may include specific recommendations and/or requirement for corrective action plans to be implemented by the *provider/participating provider*. Recommendations may include, but are not limited to:

⁶ Unless otherwise required by a specific ValueOptions client or a government agency, the initial sample size is based on the greater of five (5) records or the number of records equivalent to five percent (5%) of the total number of *members* for whom the *provider/participating provider* rendered services in the relevant audit sample date span.

- Education - Working with the ValueOptions Provider Relations team, the SIU may develop an educational program reviewing the deficiencies identified, and provide tools to assist the *provider/participating provider* in correcting such deficiencies.
- Corrective Action Plan – ValueOptions may require that the *provider/participating provider* implement and/or submit a corrective action plan for implementation clearly identifying steps the *provider/participating provider* will take to meet ValueOptions’ standards and correct all identified deficiencies. Corrective action plans should include at a minimum confirmation of the *provider’s/participating provider’s* understanding of the SIU findings and affirmation of the *provider’s/participating provider’s* agreement to carry out and/or implement all recommendations in the findings, and the specific timeframe for completion of the corrective action plan and correction of identified deficiencies.
- Repayment of Claims - The SIU will specify any requirements for repayment of amounts previously paid in either the written report of findings and/or any corrective action plans required. The repayment amount will be based on the actual deficiency determined in the sampling process. The *provider/participating provider* will be responsible for paying the actual amount owed based on ValueOptions’ findings. Once any corrective action plan is delivered, additional documentation will not be considered for the purpose of adjusting the original claims repayment amount. Required repayments must be made within (10) business days unless an installment payment plan is approved.
- Monitoring - ValueOptions may require additional monitoring of claims submissions and treatment records for additional time periods, generally periods of six (6) to twelve (12) months.

If the *provider/participating provider* disagrees with or disputes an SIU report of findings, the *provider/participating provider* may *appeal* such findings. All *appeals* must be submitted in writing and received by the ValueOptions SIU on or before the due date identified in the report of findings letter. SIU findings *appeals* must include: a copy of the SIU report of findings letter, the *provider’s/participating provider’s* name and identification number, contact information, clear identification of the findings disputed including the name or names of the *members* and associated dates of service, and an explanation of the reason/basis for the dispute. Please note that ValueOptions will not accept additional or missing documentation and/or records associated with billing errors once the SIU report of findings letter is issued.

ValueOptions will take appropriate legal and/or administrative action in the event of failure of a *provider/participating provider* to supply requested documentation and *member* records and/or failure to cooperate with an SIU investigation and/or required corrective action plan. This includes without limitation possible termination of the *provider agreement* and/or institution of actions to recovery amounts previously paid on claims involved in the SIU investigation and/or associated with SIU requests for records.

In accordance with applicable state and/or federal laws, rules and/or regulations and/or government sponsored program requirements; ValueOptions will report any suspicion or knowledge of fraud, waste and/or abuse to the appropriate authorities and/or regulatory agency. *Participating providers* are required to cooperate fully with any such external investigations and requests for access to administrative, financial and/or treatment records requested by ValueOptions and/or authorities or regulatory agencies, or their respective authorized designees.

Reporting Fraud, Waste and Abuse

Providers/participating providers should report fraud, waste and abuse, or suspicions thereof, including without limitation questionable or inappropriate billing practices (e.g., billing for services not rendered, use of diagnosis codes and/or CPT codes not evidenced in the treatment record) and/or suspicious use of or questions regarding use by a patient/*member* of another individual’s insurance/identification card of which the *provider/participating provider* is or becomes aware. Reports and questions may be made in writing to ValueOptions at the address below or by calling the ValueOptions Ethics Hotline at 1-888-293-3027.

ValueOptions, Inc.
Corporate Headquarters
240 Corporate Boulevard
Norfolk, VA 23502
ATTN: Special Investigations Unit

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Utilization Management

The ValueOptions utilization management program encompasses management of care from the point of entry through discharge using of objective, standardized, and widely-distributed clinical protocols and outlier management programs. Intensive utilization management activities may apply for high-cost, highly restrictive levels of care and cases that represent clinical complexity and risk. *Participating providers* are required to comply with utilization management *policies and procedures* and associated review processes.

Examples of review activities included in ValueOptions' utilization management program are determinations of *medical necessity, preauthorization, certification, notification*, concurrent review, retrospective review, *care/case management*, discharge planning and coordination of care.

The ValueOptions utilization management program includes processes to address: (a) easy and early access to appropriate treatment; (b) working collaboratively with *participating providers* in promoting delivery of quality care according to accepted best-practice standards; (c) addressing the needs of special populations, such as children and the elderly; (d) identification of common illnesses or trends of illness; (e) identification of high-risk cases for intensive care management; and (f) prevention, education and outreach. Objective, scientifically-based clinical criteria and treatment guidelines, in the context of *provider or member* supplied clinical information, guide the utilization management processes.

Prior to beginning a course of outpatient treatment and/or a non-emergency admission, *providers/participating providers* must contact ValueOptions to verify *member* eligibility and obtain *authorization or certification* (where applicable).

In order to verify *member* eligibility, the *provider/participating provider* will need to have the following information available: (i) the patient's name, date of birth and *member* identification number; (ii) the insured or covered employee's name, date of birth and *member* identification number; and (iii) information about other or additional insurance or health benefit coverage. Based on the most recent data provided by employer/benefit plan sponsor, benefit plan administrator and/or where applicable the sponsoring government agency, ValueOptions will: (1) verify *member* eligibility; (2) identify benefits and associated *member expenses* under the *member's* benefit plan; and (3) identify the authorization or certification procedures and requirements under the *member's* benefit plan. **Note:** Verification of eligibility and/or identification of benefits and *member expenses* are not *authorization or certification* or a guarantee of payment.

Health Plan Employer Data and Information Set (HEDIS)

On an annual basis, ValueOptions participates with our *clients* in the collection of Health Plan Employer Data and Information Set (HEDIS) data. HEDIS is the most widely used set of performance measures in the managed care industry and is maintained by the *National Committee for Quality Assurance (NCQA)*. The most current set of HEDIS measures includes 71 measures across 8 domains of care. Only a few of these measures pertain to behavioral health, but over the last few years increasing attention has been paid to developing new measures for behavioral health.

Participating providers play a critical role in ValueOptions HEDIS measure performance. The behavioral health indicators primarily address either the number or the timeliness of visits following a diagnosis of certain behavioral health disorders or treatment at specific levels of care. *Participating providers* should be aware of the standards set by these measures and must document appropriately in *members'* treatment records.

Below is a brief description of the HEDIS measures that apply to the behavioral health field and the timeframes and numbers of sessions associated with each:

For detailed information regarding these measures, definitions and national averages, go to <http://www.health.state.mn.us/divs/hpsc/mcs/hedis/home.htm>

1. Follow-up after Hospitalization for Mental Illness

This measure is described as the percentage of discharges for *members* 6 years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 7 and/or 30 calendar days of discharge.

The critical pieces of this measure for *providers/participating providers* are:

- Inpatient facilities need to:
 - Use accurate diagnoses when submitting claims for inpatient treatment. If the diagnosis on admission is a mental health diagnosis but subsequent evaluation during the stay confirms that the primary diagnosis is substance abuse, please use the substance abuse diagnosis on the claim submitted at discharge.
 - Assist in scheduling or ensure that follow-up visits are within seven (7) calendar days of discharge. **NOTE:** It is important to notify the *provider/participating providers* that the appointment is post hospital discharge and that an appointment is needed in seven (7) calendar days.
- Outpatient *providers/participating providers* need to make every attempt to schedule appointments within 7 calendar days for *members* being discharged from inpatient care. *Providers/participating providers* are encouraged to contact those *members* who are “no show” and reschedule another appointment. Claims for these visits should be submitted in a timely fashion.

2. Initiation and Engagement of Alcohol and other Drug Dependence Treatment

This measure calculates two rates using the same population of *members* with Alcohol and Other Drug (AOD) dependence:

Initiation of AOD Dependence Treatment: The percentage of adults diagnosed with AOD dependence who initiate treatment through either:

- An inpatient AOD admission, or
- An outpatient service for AOD (that can include an ER visit) AND an additional AOD service within 14 calendar days

Engagement of AOD Treatment: An intermediate step between initially accessing care and completing a full course of treatment. This measure is designed to assess the degree to which the *members* engage in treatment with two (2) additional AOD services within 30 calendar days after initiation phase ends. The services that count as additional AOD services include IOP, Partial Hospital, or outpatient treatment billed with CPT 4 or revenue codes associated with substance abuse treatment.

3. Antidepressant Medication Management

The components of this measure assess different facets of pharmacological management of depression.

Optimal Practitioner Contacts for Medication Management. This process measure assesses the adequacy of clinical management of new treatment episodes for adult *members* with a major depressive disorder.

The measure is defined as the percentage of *members*, 18 years of age and older as of April 30th of the measurement year, who were diagnosed with a new episode of depression and treated with antidepressant medication, and who had at least three follow-up contacts with a non-mental-health practitioner or mental health practitioner coded with a mental health diagnosis during the 84-day (12-week) Acute Treatment Phase.

At least one of the three follow-up contacts must be with a prescribing practitioner (e.g., licensed physician, physician assistant or other practitioner with prescribing privileges).

Effective Acute Phase Treatment: This intermediate-outcome measure assesses the percentage of adult *members* initiated on an antidepressant drug who received a continuous trial of medication treatment during the Acute Treatment Phase.

The percentage is determined by the number of *members*, 18 years of age and older as of April 30th of the measurement year, who were diagnosed with a new episode of depression, were treated with antidepressant medication and remained on an antidepressant drug during the entire 84-day (12-week) Acute Treatment Phase.

Effective Continuation Phase Treatment: This intermediate-outcome measure assesses the effectiveness of clinical management in achieving medication compliance and the likely effectiveness of the established dosage regimen.

The percentage is determined by the number of *members*, 18 years of age and older as of April 30th of the measurement year, who were diagnosed with a new episode of depression and treated with antidepressant medication and who remained on an antidepressant drug for at least 180 days (6 months).

4. Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

The following two rates in the measure assess follow-up care for children prescribed a medication to treat ADD or ADHD. Examples of the antidepressant medications included in this measure are:

- Tricyclic antidepressants (TCA) and other cyclic antidepressants
- Selective serotonin reuptake inhibitors (SSRI)
- Monoamine oxidase inhibitors (MAOI)
- Serotonin-norepinephrine reuptake inhibitors (SNRI), and
- Other antidepressants

Initiation Phase: Defined as the percentage of *members*, 6–12 years of age as of the prescription start date, with an ambulatory prescription dispensed for ADHD/ADD medication and who had one follow-up visit with practitioner with prescriptive authority during the 30-day Initiation Phase.

Continuation and Maintenance (C&M) Phase: Defined as the percentage of *members*, 6–12 years of age as of the prescription start date, with an ambulatory prescription dispensed for ADHD/ADD medication who remained on the medication for at least 210 days and had at least two additional follow-up visits with a practitioner within 9 months after the Initiation Phase ends.

New & Emerging Technologies

ValueOptions recognizes the need for knowledge of emerging technologies to provide access to optimum care for *members*. ValueOptions evaluates these technologies in terms of their overall potential benefits to *members* and in some instances recommends these technologies to clients for inclusion in their respective benefit packages. Examples of new technologies are psychotropic medications or new, approved uses of current medications, innovative community service programs and new approaches to provision of psychotherapy and treatment. ValueOptions has established

committees that conduct formal reviews of potential new technologies. The effectiveness of new service technologies will be considered in *medical necessity* decisions.

Treatment Planning

Providers/participating providers must develop individualized treatment plans that utilize assessment data, address the *member's* current problems related to the behavioral health diagnosis, and actively include the *member* and significant other, as appropriate, in the treatment planning process. *CCMs* review the treatment plans with the *providers/participating providers* to ensure that they include all elements required by the *provider agreement*, applicable government program, and at a minimum:

- a. Specific measurable goals and objectives;
- b. Reflect the use of relevant therapies;
- c. Show appropriate involvement of pertinent community agencies;
- d. Demonstrate discharge planning from the time of admission; and
- e. Reflect active involvement of the *member* and significant others as appropriate.

Providers/participating providers are expected to document progress toward meeting goals and objectives in the treatment record and to review and revise treatment plans as appropriate.

Clinical Review Process

Provider/participating provider cooperation in efforts to review care prospectively is an integral part of care coordination activities. Subject to the terms of the *member's* benefit plan and applicable state and/or federal laws and/or regulations, *providers/participating providers* must notify ValueOptions prior to admitting a *member* to any *level of care*. Some benefit plans, but not all, may allow for a designated number of outpatient sessions without prior-*authorization, certification, or notification*.

In all cases, *providers/participating providers* are encouraged to contact ValueOptions prior to initiating any non-emergency treatment to verify *member* eligibility and to clarify what are the *authorization* or *certification* requirements, if any, for the proposed treatment.

Coverage and payment for services proposed for and/or provided to *members* for the identification or treatment of a *member's* condition or illness is conditioned upon *member* eligibility, the benefits covered under the *member's* benefit plan at the time of service, and on the determination of *medical necessity* of such services and/or treatment. Overpayments made as a result of a change in eligibility of a *member* are subject to recovery.

Subject to verification of eligibility under the *member's* benefit plan, upon request for *authorization* or *certification* of services, the *Clinical Care Manager (CCM)* gathers the required clinical information from the *provider/participating provider*, references the appropriate clinical criteria for the services and/or *level of care*, and determines whether the services and treatment meets criteria for *medical necessity*. The *CCM* may *authorize* or *certify levels of care* and treatment services that are specified as under the *member's* benefit plan (e.g., acute inpatient, residential, partial hospitalization, intensive outpatient, or outpatient). *Authorizations* or *certifications* are for a specific number of services/units of services/days and for a specific time period base based on the *member's* clinical needs and provider characteristics.

Prior to initial determinations of *medical necessity*, the *member's* eligibility status and coverage under a benefit plan administered by ValueOptions should be confirmed. If eligibility information is not available in non-emergency situations, a *CCM* may complete a screening assessment and pend the *authorization/certification* awaiting eligibility verification. *CCMs* will work with *members* and *providers/participating providers* in situations of *emergency*, regardless of eligibility status.

If a *member's* benefits have been exhausted or the *member's* benefit plan does not include coverage for behavioral health services, the *CCM* will provide the *member* with information about available community support services and

programs, such as local or state-funded agencies or facilities, that might provide sliding scale discounts for continuation in outpatient therapy, or where available under the *member's* benefit plan explore benefit exchanges with the client plan.

When a *provider/participating provider* requests a retrospective review for services previously rendered, ValueOptions will first determine whether such a retrospective review is available under the *member's* benefit plan and request the reason for the retrospective review (e.g., *emergency* admission, no presentation of a ValueOptions *member* identification card, etc.). In cases where a retrospective review is available, services will be reviewed as provided for in this *handbook*. In cases where a retrospective review is not available under the *member's* benefit plan and/or where the *provider/participating provider* fails to follow administrative process and requirements for *authorization, certification* and/or *notification*, the request for retrospective review may be administratively denied. Subject to any client, government sponsored health benefit program and/or benefit plan specific requirements, the chart below references the standard timeframes applicable to the type of review request.

Standard Timelines for Determinations of <i>Medical Necessity</i>		
Request Type	Timing of Request	Determination
Prospective (Initial) Urgent	Prior to treatment	72 hrs from request
Prospective (Initial) Non-urgent	Prior to treatment	15 calendar days from request
Concurrent Urgent	Requested >24 hrs of authorization expiration	24 hrs from request
Concurrent Urgent	Requested <24 hrs from authorization expiration	72 hrs from request
Concurrent Non-Urgent	Prior to auth expiration	Reverts to Prospective (72 hrs/15 calendar days) from request
Retrospective	After services rendered	30 calendar days from request

ValueOptions' procedures for authorization, *certification* and/or *notification* apply to services and treatment proposed and/or previously rendered in instances where the *member* benefit plan administered by ValueOptions is primary and instances where the *member* benefit plan administered by ValueOptions is secondary.

ValueOptions, at times, may administer both primary and secondary benefit plans of a given *member*. To avoid possible duplication of the review process in these cases, *providers/participating providers* should notify ValueOptions of all pertinent employer and other insurance information for the *member* being treated.

Note: Failure to follow *authorization, certification* and/or *notification* requirements, as applicable, may result in administrative denial/non-certification and require that the *member* be held harmless from any financial responsibility for the *provider's/participating provider's* charges.

Definition of Medical Necessity

Unless otherwise defined in the *provider agreement* and/or the applicable *member* benefit plan and/or the applicable government sponsored health benefit program, ValueOptions' reviewers, *Clinical Case Managers, Peer Advisors*, and other individuals involved in ValueOptions' utilization management processes use the following definition of *medical necessity* or *medically necessary* treatment in making *authorization* and/or *certification* determinations:

- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (ICD-9 or DSM-IV-TR) that threatens life, causes pain or suffering, or results in illness or infirmity
- Expected to improve an individual's condition or level of functioning

- Individualized, specific and consistent with symptoms and diagnosis, and not in excess of patient's needs
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications
- Reflective of a level of service that is safe, where no equally effective, more conservative and less costly treatment is available
- Not primarily intended for the convenience of the recipient, caretaker or *provider/participating provider*
- No more intensive or restrictive than necessary to balance safety, effectiveness and efficiency
- Not a substitute for non-treatment services addressing environmental factors

Clinical Criteria

The clinical criteria used by ValueOptions to make admission, *level of care* and continuing treatment decisions reflect ValueOptions' philosophy and clinical values. To determine the appropriate *level of care* during a review the *Clinical Care Manager (CCM)* evaluates the pertinent clinical information relative to the *levels of care* criteria. These clinical criteria are assessed, revised where necessary and approved and/or adopted at least annually by the ValueOptions Corporate Executive Medical Management Committee (EMMC) and Clinical Advisory Committees. Sources for various clinical criteria include:

- The American Psychiatric Association Manual for Peer Review
- The Diagnostic and Statistical Manual IV-TR
- The American Accreditation HealthCare Commission/URAC standards
- The American Society of Addiction Medicine standards (ASAM)
- The American Society of Addiction Medicine PPC-2 Criteria
- Health Management Strategies International Mental Health Review Criteria
- Discussions with senior consultants in the field
- Various criteria sets from other utilization management entities and third party payers

Clinical criteria may vary according to individual contractual requirements and benefit coverage. Access to current clinical criteria is available on the *website*.

Treatment Guidelines

In addition to clinical criteria, ValueOptions has a set of Diagnosis-Based Treatment Guidelines. These guidelines are used in collaboration with *providers* to help guide appropriate and clinically effective care for a variety of complex psychiatric conditions. These guidelines represent standards of best practice for treating these complex conditions and can be referred to by *Clinical Care Managers (CCM)* and *Peer Advisors (PA)* during reviews. ValueOptions seeks input from *participating providers*, consultants, and other expert clinicians to develop some of the guidelines; however in most instances ValueOptions adopts established and/or published guidelines such as those developed by the American Psychiatric Association (e.g., Bipolar, Major Depression, Schizophrenia, Eating Disorder and ECT). Information about and access to Treatment Guidelines used by ValueOptions is available on the *website*.

ValueOptions' Care Management System

Members and *participating providers* may access the ValueOptions care management system through any of the following avenues:

- 24-hour toll-free emergency care/clinical referral line
- Direct registration of care through the Interactive Voice Response (IVR) system (in those local ValueOptions Service Centers where IVR is used)
- Direct *authorization/certification* of all *levels of care* through referral by a ValueOptions' *Clinical Care Manager (CCM)*

- Emergency services through freestanding psychiatric hospitals, medical hospitals with psychiatric units, emergency rooms or crisis response teams
- On-line applications through ProviderConnect

If a call is received from a *member* requesting a referral and/or information about *participating providers* in the *member's* location, *CCMs* may conduct a brief screening to assess whether there is a need for urgent or emergent care. Referrals are made to *participating providers*, taking into account *member* preferences such as geographic location, hours of service, cultural or language requirements, ethnicity, type of degree the *participating provider* holds and gender. Additionally, the *member* may require a clinician with a specialty such as treatment of eating disorders. In all cases, where available, the *CCM* will provide the *member* with the name, location and phone number of at least three *participating providers*.

Clinical Care Manager Reviews

ValueOptions' *Clinical Care Managers (CCMs)* base reviews on established criteria adopted by ValueOptions and/or criteria developed by ValueOptions. *CCMs* are trained to match the needs of *members* to appropriate services, *levels of care*, treatment and length of stay, and community supports. This requires careful consideration of the intensity and severity of clinical data presented, with the goal of quality treatment in the least restrictive environment. The clinical integrity of the utilization management program seeks to provide that *members* who present for care are appropriately monitored and that comprehensive reviews of all *levels of care* are provided. Those cases that appear to be outside of best practice guidelines are referred for specialized reviews. These may include evaluation for intensive care management, clinical rounds, *peer advisor* review or more frequent *CCM* review.

CCMs obtain clinical data from the *provider/participating provider* or designee relating to the need for care and treatment planning. The *CCM* evaluates this information and references applicable clinical criteria to determine *medical necessity* of the requested *level of care* or service. Where appropriate, care is *pre-certified* for a specific number of services/days for a specific time period at a specific *level of care*, based on the needs of the *member*.

Except where disclosure of certain information is expressly prohibited by or contrary to applicable state or federal laws or regulations, *participating providers* must be prepared to provide ValueOptions with the following information at the time of the review, as necessary and appropriate:

- Demographics
- Diagnosis (DSM-IV-TR or ICD-9, Axes I-V; for GAF score, note current, highest in past year and score expected at discharge)
- Reason for admission/precipitant
- Suicidal/homicidal risk, including
 - ideation
 - plan
 - intent
 - psychotic/non-psychotic (e.g., command hallucinations, paranoid delusions)
- Chemical Dependency/Substance Abuse history
 - type
 - amount
 - withdrawal symptoms
 - vital signs
 - date(s) of initial use and last use
 - date(s) of periods of sobriety
- Medical problems
 - medical history
 - organic cause of psychiatric symptoms/behaviors
 - medical problems which exacerbate psychiatric or substance abuse symptoms/behaviors
- Current medications

- types(s)
- dosage(s)
- date(s)
- duration
- response
- provider(s)
- Primary care physician (PCP) interface, if applicable
- Other behavioral health care provider interface, if applicable
- General level of functioning
 - sleep, appetite
 - mental status
 - ADLs (Activities of Daily Living)
- Psychological stressors and supports
 - socioeconomic
 - family
 - legal
 - social
 - abuse, neglect, domestic violence (as appropriate)
- Response to previous treatment
 - previous treatment history, most recent treatment, past treatment failures
 - relapse/recidivism, motivation for treatment
 - indications of compliance with treatment recommendations
- Treatment plan
 - estimated length of stay
 - treatment goals
 - specific planned interventions
 - family involvement
 - precautions for specific risk behaviors
 - educational component for regulatory compliance and substance abuse situations
- Discharge plan
 - aftercare required upon discharge
 - barriers to discharge

Inpatient or Higher Levels of Care

All inpatient and alternative *level of care* programs (this does not include outpatient therapy rendered in a *provider's/participating provider's* office or outpatient therapy in a clinic or hospital setting) will be subject to the review requirements described in this section. Prior to non-emergency admission and/or beginning treatment, the *provider/participating provider* must contact ValueOptions:

- For *notification*
- To confirm benefits and verify *member* eligibility
- To provide clinical information regarding the *member's* condition and proposed treatment
- For *authorizations* or *certifications*, where required under the *member's* benefit plan

Clinical Care Managers (CCMs) and/or Referral Line Clinicians are available seven (7) days a week, twenty-four (24) hours a day, three hundred sixty-five (365) days a year to provide assessment and referral and conduct *authorization* or *certification* reviews.

Where *authorization*, *certification* or *notification* is required by the *member's* benefit plan and unless otherwise indicated in the *provider agreement*, *providers/participating providers* should contact ValueOptions within twenty-four (24) hours of any *emergency* admission for *notification* and/or to obtain any required *authorization* or *certification* for continued stay.

If prior to the end of the initial or any subsequent *authorization* or *certification*, the *provider/participating provider* proposes to continue treatment, the *provider/participating provider* must contact ValueOptions for a review and recertification of *medical necessity*. It is important that this review process be completed more than 24 hours *prior* to the end of the current *authorization* or *certification* period.

Continued stay reviews: (a) focus on continued severity of symptoms, appropriateness and intensity of treatment plan, *member* progress and discharge planning; and (b) involve review of treatment records and discussions with the *provider/participating provider* or appropriate facility staff, *EAP* staff or other behavioral health *providers* and reference to the applicable clinical criteria. In instances where the continued stay review by a *CCM* does not meet clinical criteria and/or where questions arise as to elements of a treatment plan or discharge plan, the *CCM* will forward the case file to a *Peer Advisor* for review.

Note: For some benefit plans, *authorization* and/or *certification* requests (where required) for non-emergency admissions and/or higher *levels of care* is required to be done via a faxed document, the Inpatient Treatment Report (ITR). When a *provider/participating provider* calls to request *authorization* or *certification* for non-emergency admissions and/or a higher *level of care*, ValueOptions will identify whether the *member's* benefit plan is one that requires submission of the ITR.

Discharge Planning

Discharge planning is an integral part of treatment and begins with the initial review. As a *member* is transitioned from inpatient and/or higher *levels of care*, the *Clinical Care Manager (CCM)* will discuss with the *provider/participating provider* the discharge plan for the *member*. The following information may be requested and must be documented:

- Discharge date
- Aftercare date
 - Date of first post-discharge appointment (must occur within 7 days of discharge)
 - With whom (name, credentials)
 - Where (*level of care*, program/facility name)
- Other treatment resources to be utilized: types, frequency
- Medications
 - Patient/family education regarding purpose and possible side effects
 - Medication plan including responsible parties
- Support systems
 - Familial, occupational and social support systems available to the patient. If key supports are absent or problematic, how has this been addressed
 - Community resources/self-help groups recommended (note purpose)
- *EAP* linkage
 - if indicated (e.g., for substance abuse aftercare, workplace issues, such as Return-to- Work Conference, enhanced wrap-around services) indicate how this will occur
- Medical aftercare (if indicated, note plan, including responsible parties)
- Family/work community preparation
 - Family illness education, work or school coordination, (e.g., *EAP* and Return-to-Work Conference) or other preparation done to support successful community reintegration. Note specific plan, including responsible parties and their understanding of the plan.

Adverse Clinical Determination/ Peer Review

If a case does not meet *medical necessity* criteria at the requested *level of care*, the *CCM* discusses the *member's* needs with the *provider/participating provider* and works collaboratively with the *provider/participating provider* to find an appropriate alternative level of care. If no alternative seems appropriate, the *CCM* cannot deny a request for services. Requests that do not meet *medical necessity* criteria or present quality of care issues are

referred to a *peer advisor* for second level review. It is important to note that only a doctoral level *peer advisor* can clinically deny a request for services. The *peer advisor* reviews the available information and may elect to conduct a Peer-to-Peer Review, which involves a direct telephone conversation with the attending or primary *participating provider* to discuss the case. Through this communication, the *peer advisor* may obtain clinical data that were not available to the *CCM* at the time of the review. This collegial clinical discussion allows the *peer advisor* the opportunity to explore alternative treatment plans with the *provider/participating provider* and to gain insight into the attending provider's anticipated goals, interventions and timeframes. The *peer advisor* may request more information from the *provider/participating provider* to support specific treatment protocols and ask about treatment alternatives.

When an adverse determination is made, the treating provider (and hospital, if applicable) is notified telephonically of the decision and asked to notify the *member*. Written notification of an adverse determination is issued to *member*, *member* representative, practitioner, and facility within decision timeframes. If an adverse decision is rendered, the *provider/participating provider* has the right to speak with the *peer advisor* who made the adverse determination by calling ValueOptions at the toll free phone number of the *member's* plan. For substance abuse treatment of minors, ValueOptions follows federal and state guidelines regarding release of information in determining the distribution of adverse decision letters.

All written or electronic adverse determination notices include:

- a. The principal reason(s) for the determination not to certify,
- b. A statement that the clinical rationale (or copy of the relevant clinical criteria), guidelines, or protocols used to make the decision will be provided, in writing, upon request,
- c. Rights to and instructions for initiating an appeal, including the opportunity to request an expedited *appeal* if applicable for first level appeals, and information about the *appeal* process,
- d. The right to request an *appeal* verbally, in writing, or via fax transmission,
- e. The timeframe for requesting an *appeal*, and
- f. The opportunity for the *member, provider/participating provider* to submit, for consideration as part of the *appeals* process, written comments, documents, records, and other information relating to the case,
- g. The *member's* right to bring a civil action under the Employer Retirement Income Security Act of 1974 (ERISA), when applicable, and
- h. The right of the *provider/participating provider* to request a reconsideration within three (3) business days of receipt of the notice when a *medical necessity* denial is issued without a Peer-to-Peer conversation having taken place, or when an administrative denial is issued because of the failure of a *provider/participating provider* to respond to a request for Peer-to-Peer conversation within a specified timeframe.

Electroconvulsive Therapy

Prior to conducting Electroconvulsive Therapy (ECT), *providers/participating providers* must contact ValueOptions for *pre-certification* of such therapy. All requests for ECT are reviewed by a clinician.

Outpatient Services

Providers/participating providers may request any required authorization or certification for outpatient services in several ways: (a) submission of a ValueOptions Outpatient Review Form (ORF) or other state required or approved outpatient review form (where applicable), (b) use of the toll-free number on the *member's* identification card for a telephonic review, or (c) electronically through ProviderConnect on the *website*. The online process available through ProviderConnect on the *website* generally takes less than 3-4 minutes per request and determinations are available immediately. In instances where a review does not meet clinical criteria and/or where questions arise as to elements of a treatment plan, the case file may be forwarded to a *Peer Advisor* for review.

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Appeal of Adverse Determinations

When authorized by the *member* and/or when a *member* assigns *appeal* rights in writing to a *participating provider*, the *participating provider* may *appeal* on behalf of the *member* adverse determinations (denials) made by ValueOptions. *Participating providers* must inform the *member* of adverse determinations and an *appeal* rights of which the *participating provider* is made aware.

Member appeal rights are limited to those available under the *member's* benefit plan, and may involved one or more levels of *appeal*.

While the number of *appeals* available is determined by the *member's* benefit plan, the type of *appeal*, 'administrative' or 'clinical', is based on the nature of the adverse determination. The *member's* care circumstances at the time of the request for *appeal* determine the category of *appeal* as urgent, non-urgent, or retrospective. The *member* benefit plan and applicable state and/or federal laws and regulations determine the timing of the *appeal* as expedited, standard, or retrospective. For example, if a *provider/participating provider* files a Level I *appeal* on behalf of a *member* in urgent care, the *appeal* is processed as an expedited *appeal*, even if the *member* is discharged prior to the resolution of the *appeal*.

Unless otherwise provided for in the *member* benefit plan, government sponsored health benefit program, or applicable state or federal law or regulation, the *provider/participating provider* and/or the *member* (or the *member's* authorized representative), has the right to file or request: (a) an initial or Level I *appeal* of an adverse determination for up to one hundred and eighty (180) calendar days from receipt of notice of the adverse determination; and (b) a second level or Level II *appeal* of an adverse determination for up to ninety (90) calendar days from receipt of notice of the Level I *appeal* determination, in those instances where a second level or Level II *appeal* is available to the *member*. Initial or Level I *appeals* may be made verbally, in writing, or via fax transmission. Unless otherwise provided for or restricted under the *member* benefit plan, government sponsored health benefit program, or applicable state or federal law or regulation, second level or Level II *appeals* may be made verbally, in writing, or via fax transmission.

The *member*, *member's* authorized representative, and/or the *provider/participating provider* may submit any information they feel is pertinent to the *appeal* request and all such information is considered in the *appeals* review, whether or not it was available to ValueOptions' reviewers during the initial determination.

The date of the request for an initial or Level I or Level II *appeal* of the adverse determination is considered the date and time the *appeal* request is received by ValueOptions.

When a *provider/participating provider*, *member* (or the *member's* authorized representative) requests an *appeal* of an adverse determination, the *provider/participating provider* may not bill or charge the *member* until all *appeals* available to the *member* have been exhausted by the *member*, and/or where applicable by the *provider/participating provider* where the *member* has authorized the *provider/participating provider* to pursue the *appeal(s)* on the *member's* behalf.

Written notice of determinations for all Level I and Level II *appeals* of adverse determinations will be made to the *member* and the *provider/participating provider* where required by the *member* benefit plan, government sponsored health benefit program, and/or applicable state or federal laws or regulations.

Unless otherwise provided for in the *member* benefit plan, government sponsored health benefit program, or applicable state or federal law or regulation, the chart below sets out the turn-around-times for completion of adverse determination *appeals* conducted by ValueOptions.

Standard Turn Around Times for *Appeal* Completion and Notice by Type of Care Request⁷

Type of Care Request At Time <i>Appeal</i> Is Filed	Appeal Type		
	Expedited <i>Appeal</i>	Standard <i>Appeal</i> (Level I or II)	Retrospective <i>Appeal</i> (Level I or II)
Urgent	Within 72 hours of receipt of the <i>appeal</i> request. <u>Notification:</u> Verbal notice to <i>provider</i> within 1 calendar day of decision; written notice to the <i>provider</i> and the <i>member</i> within the decision timeframe	N/A	N/A
Non-urgent (Standard)	N/A unless <i>provider</i> indicates that delay would impact the life or health of <i>member</i> - then process as Urgent above	Within 15 calendar days of the receipt of the request for <i>appeal</i> <u>Notification:</u> written notice to the <i>provider</i> and the <i>member</i> within the decision timeframe	N/A
Retrospective	N/A	N/A	30 calendar days from receipt of request for <i>appeal</i> ; <u>Notification:</u> written notice to <i>provider</i> and the <i>member</i> within decision timeframe

Clinical *Appeals*

Clinical *appeal* reviews of adverse *medical necessity* determinations administered by ValueOptions are conducted by a *Peer Advisor* in the same profession and/or in a similar specialty as typically manages the behavioral health condition, procedure or treatment, as deemed appropriate, or a committee of practitioners having similar qualifications of a *Peer Advisor*. Clinical *appeal* reviewers are neither the individual who made the original adverse *medical necessity* determination, nor the subordinate of such an individual.

Written notice of Level I and Level II clinical *appeal* determinations upholding the original adverse determination (or Level I *appeal* where applicable), in whole or in part, will include: (a) the principal reason or reasons for the determination; (b) reference to the clinical criteria and/or guidelines used to be made available upon request; (c) the procedures for initiating the next step in the *appeal* process, if any; (d) the right of the *member* and/or the *provider/participating provider* to submit additional information in support of the next level of *appeal*, if any; and (e) where applicable information related to the *member's* right to file suit and/or to pursue other voluntary dispute options as required by ERISA, or provisions as may required by applicable laws, regulations or government sponsored health benefits programs (e.g. Medicare Advantage or Managed Medicaid).

⁷ LACK OF INFORMATION – No extensions are allowed for lack of information or for “reasons beyond the control of ValueOptions”. If information submitted is incomplete, ValueOptions has the option of: (a) requesting the necessary information; however, the decision must still be made within the timeframe for making the *appeal* decision, or (b) making the decision based on information on hand.

Level I (Initial): Standard Appeals - Upon being assigned a case for review of an adverse determination clinical *appeal*, a *Peer Advisor* will investigate the substance of the *appeal*, including aspects of the clinical care involved, and review of documents, records, or other information submitted with the request for the Level I *appeal*, regardless of whether such information was also submitted or considered in the original adverse determination and the applicable clinical criteria. The *Peer Advisor* will attempt to contact the *provider/participating provider* (or the clinical representative of facility or program *providers/participating providers*) directly to conduct a telephonic review as appropriate. Based on consideration of all pertinent information, including relevant clinical criteria and guidelines, the *Peer Advisor* will make a determination to reverse (i.e., overturn) the original adverse determination in whole or part, or to uphold the original adverse determination.

When an adverse determination clinical *appeal* review is conducted and completed telephonically, the *Peer Advisor* will verbally inform the *provider/participating provider* of the determination. If the determination is to reverse the original adverse determination, the *Peer Advisor* will identify the length of stay, *level of care* and/or number of service units or sessions determined to be *medically necessary*. If the determination is to uphold the adverse determination, the *Peer Advisor* include any recommendations for treatment for which *medical necessity* could be confirmed and the procedure for following the next step in the *appeals* process, if any.

Expedited Appeals - An expedited *appeal* is a request to review a an adverse determination concerning admission, continued stay, or other behavioral healthcare services for a *member* who has received urgent services but has not been discharged from a facility, or when a delay in decision making might seriously jeopardize the life or health of the *member*. Only an initial or Level I *appeal* can be processed as an expedited *appeal*. ValueOptions follows the same determination procedures outlined above for standard *appeals*, but issues the decision and notification for all expedited *appeals* within 72 hours of the *appeal* request. Expedited *appeals* are conducted by a *Peer Advisor* not involved in the original adverse determination. Determinations are communicated by telephone on the same day as the determination, with written notification sent within the 72 hour timeframe.

Level II: Upon being assigned a case for review of an adverse determination clinical *appeal*, a *Peer Advisor* will investigate the substance of the *appeal*, including aspects of the clinical care involved, and review of documents, records, or other information submitted with the request for the Level II *appeal*, regardless of whether such information was also submitted or considered in the original adverse determination or the Level I *appeal* and the applicable clinical criteria. The *Peer Advisor* will attempt to contact the *provider/participating provider* (or the clinical representative of facility or program *providers/participating providers*) directly to conduct a telephonic review as appropriate. Based on consideration of all pertinent information, including relevant clinical criteria and guidelines, the *Peer Advisor* will make a determination to reverse (i.e., overturn) the Level I *appeal* determination in whole or part, or to uphold the original adverse determination and Level I *appeal* determination.

This level of clinical *appeal* involves a review of all pertinent clinical information by another *Peer Advisor* who has not been previously involved with the adverse determination, or a Level II Appeal Committee, depending on the *member's* benefit plan and what administrative activities have been delegated to ValueOptions by the client plan. When a Level II clinical *appeal* is conducted by a Level II Appeal Committee, in some circumstances and only where indicated in the notice of Level I *appeal* determination the *member* may have the right to appear before the Level II Appeal Committee.

Retrospective: A retrospective clinical *appeal* is one requested after the *member* has been discharged from the *level of care* or treatment service under consideration. Retrospective clinical *appeals* of adverse determinations require that the *provider/participating provider* send in specific sections of the treatment record for review. Retrospective clinical *appeal* determination notices are issued within the decision timeframe and contain the required information outlined above under ‘Standard *Appeals*’. Note: There is only one level of retrospective *appeal*.

Administrative Appeals

Administrative *appeal* reviews of adverse determinations are conducted by the applicable local Service Center Vice President or their designee, or by a ValueOptions committee. Administrative *appeal* reviewers are neither the individual who made the original adverse determination, nor the subordinate of such an individual.

The types and levels of *appeal*, as well as decision and notification requirements mirror those described above for clinical *appeals*.

When an administrative *appeal* determination reverses the original adverse determination under *appeal*, in whole or in part, the administrative *appeal* determination includes a review of the *medical necessity* of the original adverse determination and the *appeal* decision and notification includes the result of both administrative and clinical review of the original request and associated adverse determination.

Final Appeal Level

For those benefit plans that provide for a final stage of *appeal* (clinical or administrative) for the *member*, ValueOptions will cooperate with the requirements of such final stage of *appeal* and where agreed upon with the client plan coordinate such final stage of *appeal*. Final stages of *appeal* may include reviews by an arbitration board, benefits committee, external review entities, state agency sponsored external review processes, government sponsored health benefits program medical directors, or other review entities and/or processes. Information about and procedures for such final *appeal* level, if any, will be included in notice of *appeal* determination for the last level of *appeal* available before final *appeals*.

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Quality Management/Quality Improvement

ValueOptions utilizes a Continuous Quality Improvement (CQI) philosophy through which ValueOptions directly or through its authorized designees, monitors and evaluates appropriateness of care and service, identifies opportunities for improving quality and access, establishes quality improvement initiatives, and monitors resolution of identified problem areas. This includes monitoring and evaluation of services performed by ValueOptions or its designees, as well as behavioral health services rendered by *providers* and *participating providers*.

ValueOptions’ comprehensive Quality Management Program (QMP) includes Quality Management (QM) *policies and procedures* applicable to all *participating providers*, strategies and major activities performed to provide for consistency and excellence in the delivery of services includes a program description, an annual work plan that includes goals and objectives and specific QM related activities for the upcoming year and evaluation of the effectiveness of those activities. *Participating providers* are responsible for adhering to the QMP and are encouraged to provide comments to ValueOptions regarding ongoing QMP activities.

QM Committees

The ValueOptions Executive Quality Council (EQC) has ultimate accountability for the oversight and effectiveness of the QMP. The Company Quality Council (CQC) is the body responsible for coordinating all national level Quality

Management activities and providing oversight, direction, and consultation to the local QM Committees and any local ValueOptions Service Center specific quality management programs. Local ValueOptions Service Center QM Committees are responsible for oversight of the day-to-day operations of their specific quality management programs and communication of their activities and findings back to the CQC to be incorporated back into the QMP, as well as for reporting and oversight of local quality management activities in their Service Center.

In addition, certain functional areas within ValueOptions (e.g., Claims) maintain quality management programs specific to the activities and services performed. Quality programs within functional areas are responsible for coordinating their quality management programs with the QMP by communicating their findings and activities to the CQC to be incorporated into QMP.

The EQC reviews and approves the National QM Program Description, QM Program Evaluation, and QM Work plan at least annually and at the time of any revision. The CQC receives a quarterly summary of all QM activities included in the work plan.

Scope of the Quality Management Program

The ValueOptions National Quality Management Program (QMP) monitors and evaluates quality across the entire range of services provided by ValueOptions. The QMP is intended to provide for structure and processes that lead to desired outcomes for *members*, clients, *providers/participating providers*, and ValueOptions functional areas and local ValueOptions Service Centers.

The scope of the QMP includes: (a) clinical services and utilization management programs; (b) quality improvement activities/projects; (c) outcome measurement; (d) network management/provider relations activities; (e) satisfaction surveys; (f) clinical treatment record review; (g) service availability and access to care; (h) *participating provider* quality performance; (i) complaints and grievances; (j) *member* rights and responsibilities; (k) patient safety activities; (l) clinical and administrative *appeals*; (m) quality indicator development and monitoring activities; and (n) cultural competency. Several of the above activities and processes are described in greater detail in other sections of this *handbook*.

Role of Participating Providers

Participating providers are informed about various aspects of the QMP through this *handbook*, *provider* newsletters, the *website*, direct mailings, seminars and training programs. Many of these venues allow for *participating provider* opportunities to give input into the QMP. Opportunities for *participating provider* participation and input into the QMP also include representation on the Provider Stakeholders Sub-Committee and the National Credentialing Committee as well as on various committees and sub-committees at the service center level (i.e., Local Credentialing Committee and Clinical Advisory Committees). Through these venues, *participating providers*:

- Provide input into the ValueOptions Clinical Criteria;
- Provide peer review and feedback on proposed practice guidelines, clinical quality monitors and indicators, new technology and any critical issues regarding *policies and procedures* of ValueOptions;
- Review Quality Improvement (QI) activities and make recommendations for improvement plans to improve quality of clinical care and service;
- Review, evaluate and make recommendations for the credentialing and re-credentialing of *participating providers*; and
- Review, evaluate and make recommendations regarding sanctions that result from *participating provider* performance issues.

As part of the QMP, ValueOptions incorporates principles designed to encourage the provision of care and treatment in a culturally competent and sensitive manner. These principles include: (a) emphasis on the importance of culture and diversity; (b) assessment of cross-cultural relations; (c) expansion of cultural knowledge; and (d) adaptation of services to meet the specific cultural and linguistic needs of *members*. *Participating providers* are reminded to take the cultural background and needs of *members* into account when developing treatment plans.

Quality Indicators

A major component of the QMP is the identification and monitoring of meaningful quality indicators. National level key performance indicators (kpi) are established, collected and reported for a small but critical number of performance measures across local ValueOptions Service Centers and functional areas. These key performance indicators are selected by functional areas along with associated goals or benchmarks and are approved by senior management. Measures are reported to the governing body at least annually.

Functional areas are responsible for meeting performance goals or benchmarks established for each indicator. When trends are identified, a corrective action plan is submitted to improve performance when performance objectives are not met.

Local ValueOptions Service centers are expected to identify, track and trend key performance indicators relevant to the population served that are related to *member* and behavioral health care services which may include but are not limited to: access to services, complaints and grievances, satisfaction about services and nationally recognized quality indicators such as HEDIS® whenever possible.

Potential quality of care and/or service indicators monitored by ValueOptions include, but are not limited to:

- Provider Inappropriate/Unprofessional Behavior
 - Sexual relationship with *member*
 - Seductive behavior, inappropriate physical contact
 - Aggressive behavior
 - Threats of aggressive behavior
 - Displays signs of substance abuse
 - Displays signs of mental health problems
 - Displays signs of organicity
 - Inappropriate pharmacy/drug prescribing
- Clinical Practice-Related Issues
 - Treatment Setting not Safe
 - Adequacy of assessment
 - Timeliness of assessment
 - Accuracy of diagnosis
 - Delay in treatment
 - Appropriateness of treatment
 - Effectiveness of treatment
 - Adequacy of referral
 - Failure to appropriately refer
 - Timeliness of referral
 - Failure to coordinate care
 - Abandoned *member*
 - Premature discharge
 - Inadequate discharge planning
 - Prescribed wrong, too much, too many, too little medication
 - Medication Error
 - Failure to follow Practice Guidelines
 - Failure to involve family in treatment
 - Over or under utilization of services
- Access to Care-Related Issues
 - Failure to provide appropriate appointment access
 - Lack of timely response to telephone calls
 - Prolonged in-office wait time
 - Session too short
 - Falling asleep
- Attitude and Service-Related Issues
 - Failure to maintain confidentiality
 - Poor communication skills
 - Lack of caring/concern

- Poor or lack of documentation
- Fraud and Abuse
- Failure to release medical records
- Failure to allow site visit

- Other Monitored Events

- Self Inflicted harm requiring urgent or emergent medical treatment;
- Attempted suicide by a *member* currently under treatment that results in inpatient admission;
- Unanticipated death (occurring in any setting) not related to the natural course of the *member's* medical illness or underlying condition (e.g. suicide, homicide, death by medical cause);
- Violent/Assaultive behavior with physical harm to self or others (e.g. attempted murder, actual assault);
- Serious Adverse reaction (e.g. requiring medical treatment) to treatment (e.g. neuroleptic malignant syndrome, tardive dyskinesia, other serious reaction);
- Sexual behavior with other patients or staff, whether consensual or not, while in a treatment program;
- Elopements from a hospital or RTC where the *member* is considered a danger to self or others;
- Injuries either in a facility or a *provider* office that require urgent or emergent medical treatment;
- Fire setting/property damage while in a treatment setting;
- Medication errors or major adverse drug reaction resulting in the need for urgent or emergent medical intervention;
- Withdrawal seizures while hospitalized for detoxification;
- More than three hospitalizations within (1) calendar year;
- Readmission within thirty (30) days
- Accidental injuries while in a treatment setting;
- Breach of confidentiality;
- Inappropriate or unsafe use of seclusion or restraints;
- Allegations of abuse/neglect by a *provider/facility* while in treatment;
- Any request for a change of *provider/facility* while in active treatment;
- Human rights violations (e.g. neglect, exploitation); and/or
- Other occurrences representing actual or potential serious harm to a *member* not listed above (e.g. staff misconduct, unexpected closure of a facility)

Service Availability and Access to Care

ValueOptions uses a variety of mechanisms to measure *member* access to care and *participating provider* behavioral health service availability. The following methods may be used to monitor *participating provider* behavioral health service availability and *member* access to care:

- Analysis of *member* complaints and grievances related to availability and access to care;
- *Member* satisfaction surveys specific to their experience in accessing care and routine appointment availability.
- Open shopper staff surveys for appointment availability; An approach to measuring timeliness of appointment access in which a surveyor contacts *participating provider's* offices to inquire about appointment availability and identifies from the outset of the call that he or she is calling on behalf of ValueOptions.
 - Unless other appointment availability standards are required by a specific client or government sponsored health benefit program, service availability is assessed based on the following standards for *participating providers*:
 - *Members* with life-threatening emergency needs are seen immediately;
 - *Members* with non-life-threatening emergent needs are seen within 6 hours;
 - *Members* with urgent needs are seen within 48 hours; and
 - Routine office visits are available within 10 business days.

- Follow-up calls to *members* who have requested referrals through the clinical/EAP/HPS referral line. These calls monitor the results and timeliness of referral appointments given to *members*.
- Analysis and trending of information on appointment availability obtained during site visits;
- Annual Geo-Access and network density analysis (see Network policies and procedures)

In addition to these monitoring activities, *participating providers* are required by contract to report to network management when the *participating provider* is at capacity. This assists customer service in selecting appropriate, available *participating providers* for *member* referral.

Continuity and Coordination of Care

ValueOptions monitors continuity and coordination of care throughout its continuum of behavioral health services. Monitoring may include reviews and audits of treatment records, coordination of discharge planning between inpatient and outpatient *providers/participating providers*, and monitoring *provider/participating provider* performance on pre-determined coordination of care indicators. Processes are established seeking to avoid disruption of care for the *member* when there is a change in their treating *provider/participating provider*. Such changes may include, but are not limited to:

- A *member* requires a change in *level of care*, necessitating a new *participating provider*
- There are multiple *providers/participating providers* involved in treatment simultaneously (psychiatrist for medication management, therapist for on-going treatment)
- A change in health plans or benefit plans
- Termination of a *participating provider*
- A *member* is being treated for several (co-morbid) conditions simultaneously with multiple *providers/participating providers* (both behavioral health specialists and primary care or medical specialists)

Subject to any *member* consent or authorization required by applicable state and/or federal laws and/or regulations, *participating providers* should coordinate care as appropriate, sharing information with other treating *providers/participating providers*, within the context of providing quality care and within the guidelines of protecting a *member's* privacy and confidentiality.

Treatment Record Standards & Guidelines

Member treatment records should be maintained in compliance with all applicable medical standards, laws, rules and regulations, as well as ValueOptions' *policies and procedures* and in a manner that is current, comprehensive, detailed, organized and legible to promote effective patient care and quality review. ValueOptions *policies and procedures* incorporate standards of accrediting organizations to which ValueOptions is or may be subject (e.g., the *National Committee for Quality Assurance (NCQA)* and the *Utilization Review Accreditation Commission (URAC)*), as well as the requirements of applicable state and federal laws, rules and regulations.

References to 'treatment records' mean the method of documentation, whether written or electronic, of care and treatment of the *member*, including without limitation medical records, charts, medication records, physician/practitioner notes, test and procedure reports and results, the treatment plan, and any other documentation of care and/or treatment of the *member*.

Progress notes should include what psychotherapy techniques were used, and how they benefited the *member* in reaching his/her treatment goals. Progress notes do not have to include intimate details of the *member's* problems but should contain sufficient documentation of the services, care and treatment to support *medical necessity* of same. Intimate details documenting or analyzing the content of conversations during a private counseling session or a group,

joint or family counseling session should be maintained within the psychotherapy notes and kept separate from the *member's* treatment record made available for review and audit.

Member treatment record reviews and audits are based on the record keeping standards set out below:

1. Each page in the treatment record contains the *member's* name or ID number.
2. Each treatment record includes the *member's* address, employer or school name, home telephone number, work telephone number, emergency contacts, marital status or legal status, appropriate consent forms, and guardianship information if relevant.
3. All entries in the treatment record include the responsible/treating provider's name, professional degree, and relevant identification number, if applicable.
4. All entries in the treatment record are dated.
5. The treatment record is legible to someone other than the writer. (A second surveyor examines any record judged to be illegible by one clinical surveyor).
6. Relevant medical conditions are listed, prominently identified, and revised as appropriate in the treatment record.
7. Presenting problems, along with relevant psychological and social conditions affecting the *member's* medical and psychiatric status, are documented in the treatment record.
8. Special status situations, such as imminent risk of harm, suicidal ideation, or elopement potential, are prominently noted, documented and revised in the treatment record in compliance with the ValueOptions written protocols.
9. Allergies, adverse reactions or no known allergies are clearly documented in the treatment record.
10. A medical and psychiatric history is documented in the treatment record, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports.
11. For *members* age 12 and older, documentation in the treatment record includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over-the-counter drugs. N/A if the *member* is under the age of twelve.
12. A mental status evaluation that includes the *member's* affect, speech, mood, thought content, judgment, insight, attention, concentration, memory and impulse control is documented in the treatment record.
13. A DSM-IV/ICD9 diagnosis, consistent with the presenting problems, history, mental status examination, and/or other assessment data is documented in the treatment record.
14. Treatment plans are consistent with diagnoses and have both objective measurable goals and estimated time frames for goal attainment or problem resolution.
15. The focus of treatment interventions is consistent with the treatment plan goals and objectives.
16. Each treatment record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills. For non-prescribing practitioners, each treatment record indicates what medications have been prescribed and the name of the prescriber. N/A is scored if medications are not prescribed.
17. Informed consent for medication and the *member's* level of understanding is documented.
N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber (e.g., MSW, PhD).
18. When medication is prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed. N/A is scored if medication is not prescribed or the practitioner being reviewed is not a prescriber (e.g. MSW, PhD).
19. Progress notes describe *member* strengths and limitations in achieving treatment plan goals and objectives.
20. *Members* who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate *level of care*. N/A is scored if the *member* is not homicidal, suicidal, or unable to conduct activities of daily living.
21. The treatment record documents preventive services, as appropriate (e.g. relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources).
22. The treatment record documents dates of follow-up appointments or, as appropriate, a discharge plan.
23. There is evidence that the clinical assessment is culturally relevant (i.e. addresses issues relevant to the *member's* race, religion, ethnicity, age, gender, sexual orientation, level of education, socio-economic level, etc.).
24. There is evidence that the treatment plan is culturally relevant. (i.e., addresses issues relevant to the *member's* race, religion, ethnicity, age, gender, sexual orientation, level of education, socio-economic level, etc.).

25. There is evidence in the record of coordination of care with the PCP or declination of this coordination by the *member*.
26. The treatment record has evidence of continuity and coordination of care between behavioral healthcare institutions, ancillary providers and or consultants.
27. The treatment record reflects evidence of coordination of care with other outpatient behavioral health practitioners.
28. The record reflects evidence of coordination with the *EAP* if a referral was made.

In addition to other requests for *Member* treatment records included in this *handbook* and/or the *provider agreement*, *Member* treatment records are subject to focused and random audits by ValueOptions Quality Management Department or its designee, as well to audits by state, local and federal regulatory agencies and accreditation entities to which ValueOptions is or may be subject.

Treatment Record Reviews

Participating provider participation in random treatment record reviews and audits is an integral part of ValueOptions QMP. *Participating providers* are required to cooperate with treatment record reviews and audits conducted by ValueOptions and associated requests for copies of *member* records. For the purpose of conducting retrospective case reviews, treatment records for ValueOptions *members* should be maintained for the time period(s) required by applicable state and/or federal laws and/or regulations, and as detailed in the *provider agreement*.

ValueOptions may conduct treatment record reviews: (a) on a random basis as part of continuous quality improvement and/or monitoring activities; (b) as part of routine quality and/or billing audits; (c) as may be required by clients of ValueOptions; (d) in the course of performance under a given client contract; (e) as may be required by a given government or regulatory agency; (f) as part of periodic reviews conducted pursuant to accreditation requirements to which ValueOptions is or may be subject; (g) in response to an identified or alleged specific quality of care, professional competency or professional conduct issue or concern; (h) as may be required by state and/or federal laws, rules and/or regulations; (i) in the course of claims reviews and/or audits; and/or (j) as may be necessary to verify compliance with the *provider agreement*.

Treatment record reviews and/or audits may be conducted through on-site reviews in the *participating provider's* office or facility location, and/or through review of copies of documents and records supplied by the *participating provider*. Unless otherwise specifically provided for in the *provider agreement* and/or other sections of this *handbook* with respect to a particular type of record review or audit, *participating providers* must supply copies of requested records to ValueOptions within five (5) business days of the request.

ValueOptions will use and maintain treatment records supplied by *participating providers* for review and/or audit in a confidential manner and in accordance with applicable laws and regulations regarding the privacy or confidentiality of protected health information and/or patient identifying information. Never send original records as they will not be returned at the completion of the review or audit.

Records are reviewed by licensed clinicians. Treatment records reviews and/or audits conducted as part of Quality Management activities include application of an objective instrument. The instrument is continuously under study and revision; ValueOptions reserves the right to alter/update, discontinue and/or replace such instrument in its discretion and without notice.

Following completion of treatment record reviews and/or audits, ValueOptions will give the *participating provider* a written report that details the findings. If necessary, the findings report will include a corrective action plan with specific recommendations that will enable the *participating provider* to more fully comply with ValueOptions standards for treatment records.

Improving Patient Safety

ValueOptions has a defined procedure for the identification, investigation, resolution and monitoring of potential and actual quality of care and service issues and trends. Quality of care and service issues and trends are those that decrease the likelihood of desired health outcomes and that are inconsistent with current professional knowledge. These types of issues may be identified from a variety of source, including without limitation *member* and *provider/participating provider* complaints, internal reviews, clients, government agencies and others. These concerns are resolved and monitored at both the local ValueOptions Service Center and network-wide level. Most local ValueOptions Service Centers have designated committees, in which the Service Center Medical Director participates, that oversee the investigation and resolution of these issues.

Professional Review/Fair Hearing Process

Individual *Providers/participating providers* may request a second level of *appeal/a fair hearing* when the PAC denies credentialing, re-credentialing, issues a sanction or recommends termination of participation status from the ValueOptions provider network based on quality of care issues and/or issues related to professional competence or professional conduct. Information about the *fair hearing* process is located in *appeals* section of this *handbook*.

Adverse Incidents

Participating providers are required to report to ValueOptions within twenty-four (24) hours all “adverse incidents” involving *members*. Adverse incidents are defined as “occurrences that represent actual or potential serious harm to the well being of a *member*, or to others by a *member* who is in active behavioral health treatment/*EAP* services, or has been recently discharged (i.e. within the past twelve (12) months) from behavioral health treatment/*EAP* services.” *Participating providers* should report all adverse incidents to the *Clinical Care Manager* with whom the *participating provider* conducts reviews. Examples of reportable adverse incidents include, but are not limited to:

- Self inflicted harm requiring urgent or emergent intervention (e.g., self-mutilation or attempted suicide)
- Unanticipated death occurring in any setting (e.g., suicide, homicide, death by medical cause)
- Violent/Assaultive behavior occurring in a behavioral health treatment setting and requiring urgent or emergent medical intervention (e.g., attempted murder, physical assault)
- Serious adverse reaction to treatment requiring urgent or emergent treatment in response (e.g. neuroleptic malignant syndrome, tardive dyskinesia, other serious drug reaction)
- Sexual behavior with other patients or staff, whether consensual or not, while in a behavioral health treatment setting.
- Elopements from a behavioral health treatment setting when the *member* is considered or alleged to be a danger to self or others.
- Injuries (e.g. accidents) in a behavioral health treatment setting that require urgent or emergent medical treatment
- Property damage, including that which occurs secondary to the setting of a fire, due to the intentional actions of a *member* while in a behavioral health treatment setting
- Medication errors resulting in the need for urgent or emergent medical intervention.
- Human Rights Violations (e.g. neglect, exploitation)
- Other occurrences representing actual or potential serious harm to a *member* not listed above (e.g. staff misconduct, unexpected closure of a facility). *Participating provider* reports of adverse incidents are treated confidentially and are processed in accordance with “peer protection” statutes. Based on the circumstances of each incident, or any identified trend of incidents, ValueOptions may undertake an investigation designed to provide for *member* safety. As a result, *participating providers* may be asked to furnish records, and/or engage in corrective action to address quality of care concerns and any identified or suspected deviations from a reasonable standard of care. *Participating providers* may also be subject to disciplinary action through the National Credentialing Committee based on the findings of an investigation or any failure to cooperate with a request for information pursuant to an adverse incident investigation.

Quality Improvement Activities/Projects

One of the primary goals of ValueOptions National Quality Management Program (QMP) is to continuously improve *member* care and services. Through data collection, measurement and analysis, aspects of care and service that demonstrate opportunities for improvement are identified and prioritized for quality improvement activities. Data collected for quality improvement projects and activities are frequently related to key performance industry measures of quality that tend to focus on high-volume diagnoses or services and high-risk diagnoses, services, or special populations. Data collected are valid, reliable and comparable over time. ValueOptions takes the following steps to ensure a systematic approach to the development and implementation of quality improvement activities:

- Monitoring of clinical quality indicators;
- Review and analysis of the data from indicators;
- Identification of opportunities for improvement;
- Prioritization, based on risk assessment, ability to impact performance, and resource availability, of opportunities to improve processes or outcomes of behavioral healthcare delivery;
- Identification of the affected population within the total membership;
- Identification of the measures to be used to assess performance;
- Establishment of performance goals or desired level of improvement over current performance;
- Collection of valid data for each measure and calculation of the baseline level of performance;
- Thoughtful identification of interventions that are powerful enough to impact performance; and
- Analysis of results to determine where performance is acceptable and, if not, the identification of current barriers to improving performance.

Satisfaction Surveys

ValueOptions, either directly or through authorized designees, conducts satisfaction surveys as a key component of the QMP. Satisfaction survey participation may include *members*, *participating providers* and/or clients.

Member satisfaction surveys measure opinions about clinical care, *participating providers*, and ValueOptions' administrative services and processes. *Members* are asked to complete satisfaction surveys at various points in the continuum of care and/or as part of ongoing quality improvement activities. The results of these *member* surveys are summarized on a semi-annual basis. Where appropriate, corrective actions are implemented in the ValueOptions' functional department or as applicable in the local ValueOptions' Service Center.

Annual *Participating provider* satisfaction surveys measure opinions regarding clinical and administrative practices. The results of *participating provider* surveys are aggregated and used to identify potential improvement opportunities within ValueOptions and possible education or training needs for *participating providers*. Where appropriate, corrective actions are implemented in the ValueOptions' functional department or as applicable in the local ValueOptions Service Center.

Site Visits for Quality Reviews

ValueOptions, or its designee, conducts site visits at *participating provider* facilities and/or offices. A site visit may be conducted as part of monitoring an investigation stemming from a *member* complaint or other quality issue. The current ValueOptions QM site visit tool and associated forms are available for review on *website*. ValueOptions reserves the right to modify or replace the site visit tool and associated forms without notice.

ValueOptions will contact the *participating provider* to arrange a mutually convenient time for the site visit. The QM site visit process is intended to be consultative and educational. Following the site visit, the *participating provider* will receive

a written report detailing the findings of the site visit. If necessary, the report will include an action plan that will provide guidance in areas that the *participating provider* needs to strengthen in order to be in compliance with ValueOptions' standards.

Complaints and Grievances

One method of identifying opportunities for improvement in processes at ValueOptions is to collect and analyze the content of *member, provider/participating provider*, and client complaints. The ValueOptions complaints and grievance process has been developed to provide a structure timely responses and for local ValueOptions Service Centers to track and trend complaint and grievance data by providing categories into which complaints and grievances may be sorted. Local ValueOptions Service Center complaints and grievance data is compiled and reported to the ValueOptions Quality Management Committee (QMC) at least quarterly.

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Appendices

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