



Kaiser Permanente Frequently Asked Questions

Q: What is the effective date that this transition will occur?

A: The *ValueOptions/Kaiser* Permanente Service Center became operational on May 1, 2006. Kaiser Permanente contracted with *ValueOptions* and its associated treatment providers to develop a comprehensive provider network.

Authorization for Care:

Inpatient Level of Care

If you are treating a Kaiser Permanente member at an **Inpatient level of care** that previously required telephone authorization prior to January 1, 2011 you will need to call ValueOptions® at 866-702-9026 to register the admission and then to review until discharge and/or a lower level of care is needed. At the point any member needs a step-down level of care; you must contact ValueOptions® to preauthorize this care.

Alternative Level of Care (Residential, Partial, Intensive Outpatient, etc.)

For alternative level of care providers will need to contact ValueOptions® at **866-702-9026** to authorize care

Continued Stay review:

Inpatient and higher levels of care (PHP, IOP) require telephonic review with a ValueOptions® Clinical Care Manager. All requests for authorization of continued stays should be made in advance of the expiration of the preauthorization so that no lapse in services occurs. . **Please note that it is the provider's responsibility to call ValueOptions® to request continued stays or concurrent reviews.** Providers should make these telephone calls according to the instructions contained in our **Provider Manual which can be accessed at www.valueoptions.com.**

Failure to initiate concurrent review telephone calls by providers may result in non-payment of claims.

Outpatient Levels of Care

Currently, ValueOptions® requires that all outpatient services, provided after a (n) employee's/member's pass through visits or registration requirement, be preauthorized. This pre-authorization requirement however, as well as any registration requirements will be discontinued as of January 1, 2011. ValueOptions® will utilize three levels of outpatient outlier management:

- Outlier management by diagnostic category
- Complex and high cost cases
- Provider outlier management

Outlier Management by diagnostic category: For cases with diagnoses that have extreme variability in treatment duration, intensity and outcome, ValueOptions® will request detailed information for review.

Complex and high cost cases: For individual members with complex illness, ValueOptions® will contact the treating provider early in the treatment regimen in order to develop, in conjunction with the provider, an individualized care plan.

Provider outlier management: If an individual provider's treatment patterns within a diagnosis vary significantly from norms, additional information will be requested for review

In addition to the clinical management strategies outlined above in response to FMHP, ValueOptions® will continue its focus on discharge planning, follow up after discharge; intensive case management, integrated and coordination of care, as well as member follow up with referral in urgent and emergent situations. We also offer select network practitioners access to our *On Track* management tool as an efficient means for monitoring employee/member outcomes.

Providers should **submit claims** in accordance with ValueOptions' claims procedures. Details regarding ValueOptions® claims procedures can be accessed through the ValueOptions® website (www.valueoptions.com).

Provider Network – Contracting and Credentialing

Q: I currently participate with ValueOptions®. What do I have to do?

A: Kaiser Permanente will require a HMO addendum. You will receive a letter from Kaiser Permanente and ValueOptions® notifying you of this change and necessary actions.

Q: I am not a provider in the ValueOptions® network. What do I do to join the network?

A: If you are not a contracted provider with ValueOptions® please note the following:

ValueOptions® and Kaiser Permanente are currently reviewing our mutual network coverage areas, clinical specialty needs, and member access. It is our intent to minimize care disruption of any members in active treatment and to that end, ValueOptions® will send copies of an agreement and addendum outlining the business rules as well as a ValueOptions® Commercial Fee Schedule attachment Kaiser Permanente., ValueOptions® will notify those providers needed for the network via mail to determine your level of interest in joining the ValueOptions® network.

What Do I Do Next?

ValueOptions® will continue to update this Frequently Asked Questions' (FAQ) document when more information is available. If you have questions please call the ValueOptions® National Provider Line at 1-800-397-1630

Q: What fee schedule will be used if I am intending on becoming a ValueOptions® provider?

A: The ValueOptions® Commercial Fee Schedule details the payment (by CPT Code and licensure) that you will receive for providing services to the Commercial/ Non-HMO Network and HMO membership.

Q: My current Outpatient fee schedule is more favorable than ValueOptions' fee schedule. With whom do I discuss my ValueOptions® fee schedule? (For individual practitioner's or outpatient clinics/groups only)

A: ValueOptions' fee schedules for outpatient services are reviewed routinely and at present are determined to be competitive with other companies with similar HMO business across the United States. In general, our fee schedules for outpatient services are non-negotiable.

If you believe that your fee schedule needs to be reviewed, please submit a Letter of Request regarding Rate Schedule to:

Cathy Gilbert, Vice President of Provider Relations ValueOptions
48561 Alpha Drive
Suite #150 Wixom,
MI 48393

You must include the following in the letter:

- Last Name, First Name
- Tax Identification or Social Security number
- Primary Mailing Address, City, State, Zip
- Practice address(s) with City, State, Zip
- Primary contact number with area code
- Name of Primary contact if different than your own
- List of codes and counter proposed rates

Q: My current Inpatient/Alternative Levels of Care fee schedule is more favorable than ValueOptions' fee schedule. With whom do I discuss my fee ValueOptions® fee schedule? (For Inpatient facilities only).

A: ValueOptions' reimbursement schedules for inpatient services have been determined to be competitive with other companies with similar HMO business across the United States. In general, our inpatient reimbursement schedules are non-negotiable. If you believe that your fee schedule needs to be reviewed, please submit a Letter of Request regarding Rate Schedule to:

ValueOptions
Cathy Gilbert, Vice President of Provider Relations
48561 Alpha Drive
Suite #150 Wixom, MI
48393

You must include the following in the letter:

- Facility Name

- Tax Identification number
- Primary Mailing Address, City, State, Zip
- Practice address(es) with City, State, Zip
- Primary contact number with area code
- Name of Primary contact if different than your own Levels of Care by Service Location (E.g. Inpatient and PHP for MH at 123 Brown Street)
- List of codes and counter proposed rates.

Q: Do I have to be credentialed by ValueOptions®?

A: Yes, all providers need to be credentialed to be included within the ValueOptions® network.

Q: I just completed my credentialing/recredentialing with PRO Behavioral Health; can you accept the Kaiser Permanente materials instead of me completing the ValueOptions® application?

A: No, ValueOptions® requires specific information and all providers must be credentialed by ValueOptions® in order to be considered as an in-network provider.

Online Services

Q: What online services does ValueOptions® offer?

A: ValueOptions® has enhanced our on-line services to provide added convenience for our members and providers. The following services available are:

- single and multiple electronic claims submission,
- claims status review (for both paper and online submitted claims),
- eligibility status,
- your provider practice profile

Claims

Claims for all dates of service prior to April 30, 2006 should be submitted to the claim address on the member's Kaiser Permanente ID card. Any questions regarding claims for these dates of service should be directed to Kaiser Permanente customer service number listed on the member's ID card.

Claims for services rendered by participating ValueOptions® providers with dates of service on or after May 1, 2006 should be submitted to ValueOptions® at:

PO Box 1770 Latham, NY 12110

Any questions regarding claims should be directed to ValueOptions® at 1-866-702-9026

Kaiser Permanente will be responsible for reimbursement of pre-certified inpatient admissions commencing prior to May 1, 2006 and any other services rendered **PRIOR** to May 1, 2006, therefore, please submit claims with dates of service prior to May 1, 2006 to the Kaiser Permanente address indicated on the member's ID

card.)

For outpatient and alternate level of care claims that span May 1, 2006: please split the claims according to dates of service and submit to the authorizing agent, i.e., PRO or ValueOptions®.

- Inpatient care that began before May 1, 2006 but will continue after must be authorized by PRO.
- Claims for inpatient levels of care need to be sent to the company who authorized the care.

ValueOptions® will be responsible for reimbursement of pre-certified services rendered **ON or AFTER** May 1, 2006, by ValueOptions® participating providers. Please submit these claims to:

ValueOptions PO Box 1770 Latham, NY 12110

If care takes place both before and after the May 1, 2006 implementation date, please split the claim accordingly.

Claims submitted by non-participating providers beyond the transition benefit date that are not authorized will be denied.

Q: What paper forms can be used for claims submission?

A: Providers are required to bill on standard CMS 1500 and UB92 forms. Red ink forms should be used as these can be scanned, which expedites the claim entry into the claims system. The UB92 Form can only be used for inpatient and alternative levels of care for mental health and substance abuse, not outpatient professional mental health services. The CMS 1500 form should be used for outpatient professional services.

Q: Can I submit my claims electronically to ValueOptions®?

A: Yes. CMS 1500 and UB92 electronic submissions are accepted according to guidelines contained in the ValueOptions® EDI materials found on www.valueoptions.com. If you are interested in electronic claim submission, please contact our ValueOptions® Electronic Claims Specialist at 888-247-9311. We strongly encourage providers to submit claims electronically for the efficiencies gained by both providers and in claims processing.

Q: Does the ValueOptions® electronic claims format work with MedLink and other claims clearing houses?

A: Please contact our ValueOptions® Electronic Claims Specialist at 888-247-9311. Please note: ValueOptions® does not reimburse for provider expenses associated with electronic claims submission.

Q: When ValueOptions® authorizes care is the authorization an automatic guarantee of payment for services rendered?

A: No, authorization of services is not a guarantee of payment. Payment depends on a number of factors including member eligibility, provider contract status, and benefit limits at the time care is rendered.

Q: As an individual practitioner, billing outpatient services, do I need to include the provider number on my claims?

A: Outpatient professional services must be billed on a CMS-1500 form. The following fields are required

CMS-1500 required fields:

- Insured's ID number
- Dates of service
- Patient's name
- Place of service
- Patient's birth date and gender
- Procedures, services or supplies CPT/HCPCS
- Insured's name
- Procedures, services or supplies modifier
- Patient's address, city, state, zip code and telephone number
- Charges
- Days or units
- Patient's relationship to the insured
- Federal Tax ID number and type
- Insured's address, city, state, zip code and telephone number
- Total charge
- Signature of physician or supplier including degrees
- Patient status – married / single or credentials
- Is the patient's condition related to: Employment?
- Name and address of facility where services were rendered
- Auto accident? Other accident?
- Is there another health benefit plan?
- Physician's/supplier's billing: name, address,
- Diagnosis or nature of illness or injury
- zip code and phone number

In addition, please visit www.valueoptions.com for more information on proper billing procedures.

Q: For claims previously rejected that need to be resubmitted, what do I need to do?

A: Provider should clearly write “Corrected Claim” on these types of claims and send to:

ValueOptions PO Box 1770 Latham, NY 12110

Providers need to be aware of the timely filing requirements as stated in their contract with ValueOptions®. This pertains to first time submissions, as well as re-submissions and a previously processed claim.

Q: As a facility billing for outpatient services, what information is required to be included on my claims?

A: Outpatient professional services must be billed on a CMS-1500 form. Please see the required fields listed above. In addition, please visit www.valueoptions.com for more information on proper billing procedures.

Q: As a Facility billing for services other than outpatient, how do I bill?

A: Inpatient services and Alternate Levels of Care (PHP, IOP, etc.) must be billed on a UB-92 form. The following fields are required:

UB-92 required fields:

- Provider name, address and telephone number
- Total charges
- Type of bill
- Payer
- Federal tax number
- Release of information certification indicator
- Statement covers period “From” and “Through”
- Assignment of Benefits
- Patient’s name (last, first name, middle initial)
- Insured’s name (last, first name, middle initial)
- Patient’s address
- Patient’s relationship to insured
- Birth date
- Certificate No. – Social Security Number –
- Sex
- Health Insurance Claim Identification Number
- Marital status
- Group name
- Admission date
- Principal diagnosis code
- Patient status
- Admitting diagnosis code
- Responsible party name and address
- Attending physician identification number
- Revenue code
- Provider representative
- Service date
- Date
- Service units

In addition, please visit www.valueoptions.com for more information on proper billing procedures.

Q: Who pays when the member is admitted to a medical unit for alcohol withdrawal treatment?

A: When the seriousness of the medical condition that admission to a medical unit is required and Kaiser Permanente authorizes it, the expense shall be a medical expense and processed by Kaiser Permanente.

Q: Who is responsible for members admitted to an inpatient medical unit with behavioral health issues that need to be treated?

A: Members admitted to a medical floor are the responsibility of the medical plan. Authorization is required by the medical plan and claims are paid by the medical plan. If the member is transferred to a

psychiatric or substance abuse unit (except for medical detoxification), ValueOptions[®] may need to review, authorize the care, and will be responsible for payment of the claims.

Q: Who is responsible for members admitted to a behavioral health unit?

A: For inpatient care, members admitted to a behavioral health unit require registration with ValueOptions[®]. Please contact ValueOptions[®] to register the admission. For alternative levels of care and ongoing inpatient care, a review and authorization will be required.

Q: Where do I go to have a claim question/issue resolved?

A: Please visit us on-line at www.valueoptions.com to check and review a claim status or call **1-866-702-9026**

Q: I'm used to billing a 90809 and 90802 for services. I do not see that code on your current fee schedule. Are these services reimbursable?

A: ValueOptions[®] does reimburse providers for these services at the same rate as a 90807 and 90801 respectively.

Clinical, Authorization and Quality Services

Q: What are the hours of the ValueOptions[®] Clinical Department?

A: Licensed clinicians are available 24-hours a day, 7 days a week, and 365 days a year. It is imperative that, in the event of emergent care, the provider contact ValueOptions[®] as soon as possible, but no later than 24-hours after the emergent contact/session/admission.

Q: As an inpatient Provider, how soon after an admission do I have to authorize care?

A: Registration is required for all inpatient services; however, after completing the evaluation, the provider should contact ValueOptions[®]. Please call ValueOptions[®] by dialing the number on the back of the member's insurance card to review the emergency, what services are offered, and the clinical information. This includes nights, weekends, and holidays, as our phone lines are open 24 hours a day 7 days a week, 365 days per year.

Q: As a provider, how soon will I receive a claims payment?

A: If provider submits a clean claim electronically within timely filing limits, compensation to the provider shall be at the rates specified in the reimbursement schedule and paid to the provider within 30 days.