

MVP Health Care Frequently Asked Questions/General Information

Q: What is the relationship between MVP and ValueOptions®?

A: ValueOptions® administers the mental health and substance abuse benefits for MVP. MVP has contracted with ValueOptions, Inc. (ValueOptions®) and its associated treatment providers to develop and maintain a comprehensive provider network. ValueOptions® also processes claims for behavioral health services and provides customer service support.

Q: What telephone number do I call to contact ValueOptions®?

A: For your clinical and customer service needs, the contact numbers you used under MVP will not change. Please use the same phone number on the MVP member's identification card and follow the prompts and you will be connected to ValueOptions®.

For provider contracting and credentialing questions, please contact ValueOptions® Provider Relations department at **1-800-235-3149**.

Authorization for Care

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

For inpatient and alternative levels of care:

1. If the member is enrolled in a health benefit plan sponsored by an employer with 50 or fewer total employees, providers will need to contact ValueOptions® for preauthorization of non-emergent admissions and preauthorization of post-stabilization care for emergency admissions.
2. Precertification is also required for Medicare and Medicaid. Please use the number on the back of the member's MVP identification card, and follow the appropriate telephone prompt for behavioral health care. Telephonic review is available 24 hours a day, seven days a week. If requests are not received medical records may be requested prior to authorization being given.
3. If the member is enrolled in a health benefit plan sponsored by an employer with 51 or more total employees, providers will need to contact ValueOptions® within 24 hours of admission. Please use the number on the back of the member's MVP identification card, and follow the appropriate telephone prompt for behavioral health care. If requests are not received, medical records may be requested prior to authorizations being given

Please note that it is the network provider's responsibility to call ValueOptions® to notify ValueOptions® of initial care requests, continued stays or concurrent reviews. Discharge reviews are also required with ambulatory follow up appointments needing to be scheduled within seven days. This information is found in our **Provider Manual which can be accessed at www.valueoptions.com**.

Failure to initiate concurrent review, via a telephone call or online submission, may result in non-payment of claims.

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Out of Network:

The member's benefit plan will define whether or not the member has coverage for out-of-network (OON) providers.

Outpatient level of care:

Most outpatient out-of-network benefits require preauthorization. Providers or Members can call ValueOptions® Customer Service at the number on the back of the member's MVP Health Care identification card, following the prompts to connect to ValueOptions®. Two (2) sessions will be authorized after which an outpatient treatment review is required.

Members covered through employer groups with 50 or fewer employees who are seeing in-network providers are allowed eight (8) pass through visits per member per benefit year for therapy. An ORF (Outpatient Request Form) is required at this time.

For physicians providing medication management sessions (90862) twelve (12) sessions per member per benefit year are allowed prior to required submission of the medication management form.

Forms are available at www.valueoptions.com. Forms may be submitted by using ProviderConnect at www.valueoptions.com/pcllogin or via fax. Fax numbers will be those currently used by MVP Behavioral Health Failure to submit the ORF and/or medication *management* forms may result in *non-payment* of claims.

Please note: Effective July 1st, and upon group's renewal date; those members covered through employer groups with 51 or more employees who are seeing in-network providers do not need to pre-authorize care. In place of the current pass-through/preauthorization outpatient processes, ValueOptions® will initiate an outlier care management model. This outlier model will focus on individual cases by diagnostic category where the course of treatment varies significantly from expected norms.

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

ValueOptions® will also continue its focus on members diagnosed with complex mental health and substance abuse illnesses. Although no precertification of outpatient services for these complex patients will be required, ValueOptions® will contact treating providers early in these complex patients' treatment regimens in order to develop, in conjunction with the providers, individualized plans of care. The goal of this process is to help assure, in cooperation with providers, the best possible outcome for patients. Depending upon a patient's illness, his/her care plan may include enrollment in ValueOptions® intensive care management program.

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Providers should **submit claims** in accordance with the 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 to begin to see MVP members?

A: You will need to contact ValueOptions® at 1-800-235-3149 to request a contract addition.

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

A: ValueOptions® periodically reviews our network coverage areas, clinical specialty needs, and member access. If you would like to request to be an in network provider with ValueOptions® please call ValueOptions® Provider Relations at 1-800-235-3149.

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

A: Yes, all providers need to be credentialed by ValueOptions® to be included within the MVP Health Care/ValueOptions® and CHCS IPA provider networks.

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 are available:

ProviderConnect is an enhanced version of our online transaction services. It is a self-service tool available 24/7 that gives you access to the following features: authorization requests for all levels of care, concurrent review requests and discharge reporting, single and multiple electronic claims submission, claims status review (for both paper and online submitted claims), eligibility status, enter an outpatient authorization request, submit an inquiry to customer service, your provider practice profile, and correspondence (which includes authorizations letters and the ability to print provider summary vouchers) Find more information about ProviderConnect on www.valueoptions.com

Claims

Claims for services rendered by participating ValueOptions® providers with dates of service should be submitted to ValueOptions® at:

PO Box 1408

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Latham, NY 12110

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

A: Providers are required to bill on standard CMS 1500 and UB04 forms. Red ink forms should be used as these can be scanned, which expedites the claim entry into the claims system. The UB04 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 UB04 (837P and 837I) 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 other claims clearing houses?

A: Please contact our ValueOptions® EDI Helpdesk Coordinator 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.

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CMS-1500 required fields:

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

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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 1408
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-04 form. The following fields are required:

- Servicing provider name, service address & phone #
- Type of bill
- Federal tax number
- Statement covers “From” and “Through”
- Patient’s name (last, first, middle initial)
- Patient’s address
- Birth date
- Sex
- Marital status
- Admission date
- Patient status
- Responsible party name and address
- Revenue code
- Service date
- Service units

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- Total charges
- Payer
- Release of information certification indicator
- Assignment of Benefits
- Insured's name (last, first name, middle initial)
- Patient's relationship to insured
- Certificate No. – Social Security Number – Health Insurance Claim Identification Number
- Group name
- Principal diagnosis code
- Admitting diagnosis code
- Attending physician identification number
- Provider representative
- Date
- NPI
- Provider Billing Address

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: Claims for Detox on Medical units should be submitted to MVP, regardless of when services are incurred.

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 ValueOptions® will need to review, authorize the care, and pay the claims.

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

A: Members who are enrolled in health benefit plans sponsored by employers with 50 or fewer total employees and are admitted to a behavioral health unit require an authorization by ValueOptions®. Please contact ValueOptions® and request an authorization. For members that are enrolled in health plans sponsored by employers with 51 or more employees and are admitted to a behavioral health unit, ValueOptions® requires notification within 24 hours.

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 the number on the member's MVP identification card and follow the prompts to be connected to ValueOptions®.

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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. Information can also be submitted online using ProviderConnect.

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

A: Pre-authorization is required for all non-emergent services rendered to members that are enrolled under a health plan sponsored by an employer with 50 or less employees; however, after completing the evaluation, the provider should contact ValueOptions®. Twenty four hours (24 hrs) notice requirement is required for all non-emergent services rendered to members that are enrolled under a health plan sponsored by an employer with 51 or more employees. 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: Clean claims submitted electronically within timely filing limits set out in your contract will be processed and paid or additional information requested where required within 30 days of receipt. Reimbursement for covered services shall be at the rates specified in the reimbursement in your contract.