NYC Engagement Center: Provider Handbook Supplement

Revised:
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Client Benefit Plans

Upon registering a case for certification and payment, providers must review the member's benefit plan with ValueOptions®. Each benefit plan has a specific design and may have different requirements regarding pre-certification, benefit limits, network participation and covered services.

Clinical Referral Line

The Clinical Referral Line (CRL) is available 24 hours a day, 7 days a week. Please refer to the back of the member's identification card for the toll free number. The CRL is staffed by licensed clinicians, trained in the assessment and treatment of mental health and substance abuse disorders. Staff are available to provide you with network referrals for medication evaluations, providers with specific clinical specialty areas, and higher levels of care. Please check with the CRL in order to ensure you are referring members to participating providers.

- If more than one provider is requesting authorization for a member for the same services, the member must call to clarify the request to ensure that care is being coordinated and duplication of services is not occurring.
- To assist the provider in the treatment planning process, ValueOptions® may make recommendations that the patient have a psychiatric or substance abuse evaluation when diagnostic clarification is warranted and/or medications may be appropriate for treating the member's condition.

Referral Standards: The NYC Engagement Center follows the NY State Managed Care Law standards

The following referral standards have been designed to ensure the highest quality of care for our Members. All first appointments must meet the following criteria:

- **Emergent care: Immediate access; Contact 9-1-1 for assistance.**
- Urgent care: Within 24 hours.
- Routine care: Within seven days.
- Post Hospitalization: Within 5 days of discharge

Your continued assistance in meeting these standards is appreciated!

Pre-Certification:

Pre-certification for inpatient treatment is available 24 hours a day, 7 days a week. All other levels of care can be pre-certified during normal business hours.

Providers must adhere to the following time frames to request pre-certification.
Network providers must pre-certify services as required by the benefit plan. The following timeframes for pre-certification are:

- **Inpatient:** within 24 hours of the admission
- **Alternate Levels of Care:** within 1 business day
- **Outpatient:** within 2 sessions of the start of treatment (except for clients who have a pass-through visits or do not have pre-certification requirements due to Federal Parity)
- A "Return to Treatment" is defined as a break in treatment of at least 3 months. Visits will be authorized at the time a return to treatment is registered.
- Psychological Testing must be pre-certified.

Outpatient Registration Form

Providers requesting treatment certification beyond the initial certification or pass-through visits (if applicable) must submit an Outpatient Registration Form (ORF). When a certification is issued, it specifies both the length and type of certified treatment. If benefits are exhausted while a member is in treatment, the CM will assist the provider in identifying alternatives for care. A copy of the ORF1 and ORF2 can be downloaded from our website at: www.ValueOptions.com.

- To avoid the possibility of administrative non-certification, ORFs requesting additional OPMH visits are due no less than two weeks prior to the last authorized visit.
- An ORF2 should be completed with updated clinical information for any continued authorization request. Photocopies of previously submitted ORFs will not be accepted.

Medication Management Form

Psychiatrists (MD or DO) requesting treatment certification beyond the initial certification or pass-through visits can submit a Medication Management Form. The Medication Management Form is a simplified request for authorization that allows a psychiatrist to receive 90862 and 90805 sessions. When a certification is issued, it specifies both the length and type of certified treatment. If benefits are exhausted while a member is in treatment, the CM will assist the provider in identifying alternatives for care. **The Medication Management Form can be found on our website at www.ValueOptions.com**

Coordination of Care

ValueOptions® partners with network providers to assist and support members who have concomitant behavioral health and medical conditions. ORFs require documentation that coordination of care has occurred. Documentation of medical conditions on the ORF is necessary. When documenting medical conditions, it is important to identify if the condition is stable or chronic in nature and whether the condition is being treated. This will help to save time and avoid unnecessary calls to clarify medical status when processing the ORF.

Many times, members may be receiving medications and/or other treatment from their Primary Care Physician (PCP). We urge providers to coordinate care, which includes, but is not limited to, regular contact with the member's PCP.

Intensive Case Management

It is the policy of ValueOptions® that any member with a behavioral health concern should be treated with the goal of achieving stabilization in the least restrictive level of care. Consistency, compliance and coordination of care should be established to assure effective management of complex cases. ValueOptions® affords Intensive Case Management (ICM) services to members, providing access to clinical staff who will talk to them about their lifestyle choices, review their daily routine, measure their level of depression or other mental health needs, and work with them to develop an individualized treatment plan that will help them address their behavioral health issues.

ValueOptions® encourages you to support your patient's efforts to adopt lifestyle changes that will have a positive impact on their health. If your patient provides written authorization, ValueOptions® will keep you informed about your patient(s) progress in the program. If you feel that your patient would benefit from these services, please refer to the back or the member's ID card for the toll free number, or contact your Provider Relations representative for more details. Thank you for your support of this important initiative.

Notification of Determinations (both Adverse Determinations and Authorizations)

In compliance with regulatory notification timeframes, the **provider agrees to verbally notify the member on the same calendar day of any determination.** The provider must document this verbal notification to the member in their record set. ValueOptions® will provide written notification to both the member and the provider. **Medical record sets are subject to periodic audits to ensure appropriate verbal notification timeframes have been met.**

Medical Necessity Determinations and Appeals

The New York City Engagement Center offers one internal Appeal.

- Care Managers conduct medical necessity reviews utilizing ValueOptions®' clinical criteria for mental health treatment and the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC2R) for the Treatment of Substance-Related Disorders for alcohol and substance abuse treatment.
- Peer Advisors can only render non-certifications based on medical necessity. Medical necessity denials are typically rendered subsequent to a peer-to-peer telephonic review. In order to meet regulatory and contract requirements, a Peer Advisor may render a non-certification based on his/her review of all clinical information available. In this event, the provider will be notified of the decision by phone and will be advised of the right to request a reconsideration or appeal.

If a ValueOptions® Peer Advisor makes a determination of no medical necessity for proposed services, the treating provider may request an appeal. This appeal offers the provider an opportunity to review the member's clinical condition with a Peer Advisor who was neither involved in the original adverse determination nor is the subordinate of the individual who made the adverse determination. Since the member is in a current course of treatment, it is essential that the provider request an appeal immediately. The treating provider must be available to discuss the case.

Appeals have specific timeframes per benefit plan. An appeal must be requested:

- For GHI-BMP: Within 180 days
- Medicaid: Within 90 days
- For GHI-FHP (Family Health Plus): 60 days
- For GHI Medicare Choice PPO: ValueOptions® is not delegated to handle appeals. Please refer to the adverse determination letter for the appeal instructions.
- For Great West: 90 days unless state specific exceptions dictate otherwise.
- All other commercial plans: within 90 days.

When the appeal review is completed, ValueOptions® will inform the provider and member of the decision.

Discharge Follow-Up

ValueOptions® has performance measures regarding follow-up care within 5 days* post hospitalization. The submission of claims is the outcome measure used to ensure that the patient has received this follow-up care. Providers risk significant loss of revenue when claims are not submitted in a timely manner.

Educating patients about the importance of aftercare appointments is an integral part of the inpatient stay. This education, along with comprehensive discharge planning, should begin upon admission.

A discharge appointment and ongoing behavioral health services after inpatient psychiatric hospital is an essential element in the prevention of re-hospitalization. The discharge plan should be individualized to meet the patient's need for treatment, provide readily accessible services, and be designed to ensure ongoing participation. In addition, this is an opportunity for the patient to receive follow-up medical care. The Primary Care Physician's name and telephone number is listed on the member's benefit card. We urge our providers to assist us in meeting the highest standards of care by ensuring appropriate aftercare for patients.

*Refers to NY State Managed Care Law. Please note: Health Plan Employer Data Information Set (HEDIS) requires follow-up in 7 days.

Participating Provider Responsibilities

Adverse Incident Reporting

It is the policy of ValueOptions® to investigate and act on adverse incidents. **Network providers are responsible for reporting adverse incidents to ValueOptions® within one business day and cooperate with the investigation and resolution of any incidents.** An adverse incident is an occurrence which represents actual or potential serious harm to the well being of the member or to others by the member while a member is in treatment. Adverse incidents include, but are not limited to, the following categories:

- Self-inflicted harm requiring urgent of emergent treatment
- Unanticipated death not related to the natural course of patient's medical illness or conditions
- Violent/assaultive behavior with physical harm to self or others
- Serious adverse reactions to treatment (tardive dyskinesia, NMS, other serious drug reaction)
- Sexual behavior with patients or staff whether consensual or not, while in a treatment program
- Elopements from hospital or RTC when patient is considered dangerous to self or others
- Injuries sustained in a facility of provider office that require urgent or emergent medical treatment

- Fire setting/property damage while in a treatment setting
- Medications errors resulting in need for urgent or emergent medical intervention

Providers must supply copies of requested medical records to ValueOptions® within five (5) business days. ValueOptions® will treat any such records in accordance with all applicable laws and regulations regarding confidentiality of records. ***Please see the section on Participating Provider Responsibilities found in the ValueOptions® Provider Handbook for more information.***

Claims Payment

Timely Filing

Claim filing guidelines may differ according to client-specific requirements or state law. To inquire, please call the toll-free number on the back of the Member ID card.

- For **Medicaid, GHI Medicare Choice PPO and GHI Family Health Plus PPO plans**, "clean claims" must be submitted no later than 180 days from the date of service. Payments will be made by ValueOptions® in accordance with NYS Prompt Pay guidelines.

- For the **GHI-BMP** benefit plan, "clean claims" must be submitted no later than 365 days following the last authorized date of service. Payments will be made in accordance with NYS Prompt Pay guidelines.

- For the **Great West** plan, "clean claims" must be submitted no later than 90 days from the date of service (subject to state specific exceptions).

- For all other **Commercial** plans, "Clean claims" must be submitted no later than 90 days from the date of service.

Billing Manuals can be found on our website www.ValueOptions.com

The claim must match the authorization for a claim to be paid correctly.

Paper Claim Submissions:

Psychological Testing

Do:

- 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 correction tape for corrections
- Submit notes on 8 ½" x 11" paper
- Use a 8-digit date format (e.g., 10212000)
- Use a fixed width font (Courier for example)
- Use the patient's date of birth

Do Not:

- Do not use black claims forms if at all possible
- Do not hand print or hand write your forms
- If you must hand print, use neat block letters that stay within field boundaries
- Do not use copies of claim forms
- Do not submit photocopied or faxed claims forms
- Do not use red ink unless for internal use only
- Do not use dashes or slashes in date fields
- Do not circle charge amounts
- Do not use fonts smaller than 8 point, 10 point is preferred
- Do not use a dot matrix/impact printer
- Do not use rubber signature stamps
- Do not use correction fluid
- Do not put notes anywhere on the claim form
- Do not use labels, stickers or stamps
- Do not apply a handwritten signature
- Do not use proportional fonts (Times New Roman is an example of a proportional font)
- Do not use mixed fonts on the same form
- Do not use italics or script fonts
- Do not submit more than six lines on the HCFA – 1500 claim form
- Do not print slashed zeros
- Do not use highlighters to highlight field information as this often causes the field data to turn back and become unreadable.

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