VNSNY CHOICE Medicare
Provider Frequently Asked Questions

This FAQ document will continue to be reviewed and updated frequently in order to provide the most current and pertinent information.

Q. What New York State Counties are included in VNSNY CHOICE Medicare?

A. ValueOptions is now managing the behavioral health benefits for VNSNY CHOICE Medicare members in the following New York State counties:

- Bronx
- Kings
- New York
- Queens
- Richmond
- Nassau
- Suffolk
- Westchester
- ***Saratoga**
- ***Albany**
- ***Schenectady**
- ***Rensselaer**

**Effective January 1, 2014, county was approved for all Medicare Advantage plans except Total and Maximum Benefit plans.*

Q. Do I have to pre-certify Outpatient services (excluding PHP and IOP)?

A. Any questions regarding outpatient pre-certification requirements should be directed to ValueOptions at 1-866-317-7773. Members are allowed 5 visit pass throughs for outpatient mental health and outpatient substance abuse levels of care whereby no precertification is required. Please submit claims for the initial 5 visits directly to:

ValueOptions
P.O. Box 1380
Latham, NY, 12110

If additional sessions are needed beyond the initial 5, please submit an Outpatient Review Form (ORF) at least 2 weeks prior to the 5th visit. ORFs can be faxed to 212-560-7778.

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Q. Do I have to pre-certify Inpatient and Alternative Levels of Care (i.e. PHP, IOP, Day Treatment)?

A. Preauthorization is required for all inpatient and higher levels of care (IOP, PHP) for both mental health and substance abuse services. To pre-certify care, providers should remember the following:

   a. Contact ValueOptions at 1-866-317-7773 for pre-certification of services for admission to inpatient levels or alternative levels of care.

   b. ValueOptions is staffed by clinical care managers for receipt of urgent and emergency calls 24 hours a day, 7 days a week, and 365 days per year.

   c. Preauthorization is not required for emergency care. ValueOptions covers emergency services necessary to screen and stabilize members without requiring pre-certification wherein a prudent layperson believes that an emergency medical condition exists. Providers are required to call the ValueOptions within 24 hours of admission.

Q. How are continued stay reviews handled?

A. Continued stay review, for inpatient and higher levels of care (PHP, IOP, Day Treatment, etc.) requires 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 pre-certification 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.** ValueOptions' participating providers should make these telephone calls according to the instructions contained in the ValueOptions' Provider Handbook, which can be accessed at www.valueoptions.com. Failure to initiate concurrent telephonic review by ValueOptions' participating providers may result in non-payment of claims.

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Provider Network – Contracting and Credentialing

Q. What fee schedule will be used if I am both a VNSNY CHOICE Medicare and ValueOptions provider?

A. The ValueOptions New York Medicare Professional Reimbursement fee schedule will be used when seeing VNSNY CHOICE Medicare members.

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. Do I have to be approved by CMS to treat VNSNY CHOICE Medicare members?

A. Yes, in order to treat VNSNY CHOICE Medicare members, providers must be approved by the Centers for Medicare and Medicaid Services (CMS) to treat Medicare Advantage members.

More specifically, Institutional Provider and Supplier Certification is required. A managed care organization must ensure that Medicare-covered basic benefits are provided only by providers that have signed participation agreements ("provider agreements") with CMS, and by suppliers approved by CMS as meeting conditions for coverage of their services.

Providers can go to www.cms.hhs.gov/providers/enrollment/providers/enroll.asp to obtain the required UPIN Number.

Q. What are the minimum credentialing requirements for practitioners to join the network?

A. ValueOptions will review each practitioner's and facility's request to join the network. ValueOptions considers each request independently and will make a final decision based on need.

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Q. When did ValueOptions begin managing VNSNY CHOICE Medicare?

A. On January 1, 2008 ValueOptions began managing the behavioral health benefits for VNSNY CHOICE Medicare in select counties of New York.

Q. Can the rates be negotiated?

A. The Fee Schedule is non-negotiable.

Q. What do I do if I want to opt out of the VNSNY CHOICE Medicare network?

A. **If you opt out of VNSNY CHOICE Medicare, you are then opting out of the ValueOptions Medicare network.** Send your written objection to Provider Relations, 433 River St., Troy, NY 12181. Be sure your letter states what you are objecting to.

Online Services

Q. What online services does ValueOptions offer?

A. ValueOptions has enhanced our online services to provide added convenience for our members and providers. The following online 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: single and multiple electronic claims submission, claims status review (for both paper and online submitted claims), eligibility status, your provider practice profile, and correspondence (which includes authorizations). Find more information about ProviderConnect on www.valueoptions.com.

Claims

Claims should be submitted to the below claims address.

ValueOptions
P.O. Box 1380
Latham, NY, 12110

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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 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, for accounts in which ValueOptions pays the claims. 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 1-888-247-9311. 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 the MedLink and other claims clearinghouses?

A. Please contact our ValueOptions Electronic Claims Specialist at 1-888-247-9311. 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 phone number • Patient's relationship to the insured • Insured's address, city, state, zip code, and phone 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 • 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

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
P.O. Box 1380
Latham, NY 12110

Providers need to be aware of the 90 day timely filing requirement for VNSNY CHOICE Medicare members. This pertains to first-time submissions as well as resubmissions and a previously processed claim.

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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, Day Treatment, etc.) must be billed on a UB-92 form. The following fields are required:

UB92 Required Fields:

• Provider name, address, & phone number • Type of bill • Federal Tax Number • Statement covers period "From"and "Through" • Patient's name (last, first, and 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 • Total charges • Payer • Release of information certification indicator • Assignment of Benefits • Insured's name (last, first, and 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

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

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

A. Admissions to a behavioral health unit require authorization by ValueOptions. Please contact ValueOptions at **1-866-317-7773** and request an authorization.

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

A. Please visit us online at www.valueoptions.com to check and review a claim status or call ValueOptions at **1-866-317-7773**.

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 90807and 90801 respectively.

Clinical, Authorization, and Quality Services

Q. What are the hours of ValueOptions Clinical Department?

A. Licensed clinicians are available 24 hours a day, 7 days a week, and 365 days per 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 impatient Provider, how soon after an admission do I have to authorize care?

A. Pre-certification is required for all services; after completing the evaluation, the provider should contact ValueOptions by dialing **1-866-317-7773**. This includes nights, weekends, and holidays, as our phone lines are open 24 hours a day, 7 days a week, and 365 days per year.