ValueOptions® Maryland
FAQ (Frequently Asked Questions)

August 24, 2009

The series of questions and answers below are intended to assist various Maryland Stakeholders with the transition to ValueOptions®, effective September 1, 2009. This FAQ document will continue to be reviewed and updated frequently in order to address as many questions/issues as possible.

Authorizations:

1. **Q. Do current authorizations expire on August 31st or will they be extended?**
   A. Any authorization issued by APS will be honored by ValueOptions®. The authorization dates will transfer from APS to ValueOptions®.

2. **Q. Will blanket authorizations be given?**
   A. No

3. **Q. What is the procedure for after-hours authorizations?**
   A. On line authorization requests can be submitted 24/7 online via ProviderConnect. In addition, ValueOptions® has telephonic coverage for high levels of care, 24/7, including Holidays provided by Maryland Licensed Care Managers.

4. **Q. What is the authorization process for lower levels of care—crisis beds, dual diagnosis substance abuse programs, Partial Hospitalization Programs (PHP), Intensive Outpatient Programs (IOP), Psychiatric Rehabilitation Programs (PRP), respite and outpatient (OP)?**
   A. Authorization processes and procedures are not changing. Authorizations may be obtained online or telephonically.

5. **Q. How will authorizations requests be acknowledged?**
   A. Authorization decisions will be available online via ProviderConnect. Providers have the option to print the authorization. A letter can also be generated and mailed to the provider, at the provider's request.

6. **Q. How will adoption cases be handled? There are issues with names and new Medicaid and Social Security numbers.**
   A. We understand that these children are assigned new Medicaid Identification and Social Security numbers. We will link the new numbers to the old numbers in our system so that we can find the eligibility and

history using either the old or new numbers. Providers should contact Customer Service for assistance with these cases.

7. **Q. What is the process for obtaining additional authorized units of service, if all the initially authorized units are used prior to the authorization expiration date?**
   A. Processes and procedures are not changing. All levels of care require pre-authorization except emergency treatment. Authorization requests for additional units can be submitted on line or telephonically.

8. **Q. How will returned treatment plans be handled? Will they be returned electronically or will a Care Manager call the provider?**
   A. A Care Manager will call the provider to review the treatment plan.

9. **Q. Will one authorization cover both facility and provider for both IP and OP visits?**
   A. One professional service can be billed for each authorized inpatient day. The answer is pending for outpatient hospital based clinic services e.g. medication management visits.

10. **Q. How will "unique special needs" cases be handled, especially if they require extended lengths of stay?**
    A. These will require MHA approval.

11. **Q. Does Value Options® accept Evaluation and Management (E&M) codes for any services, specifically 99211 to be used when the patient sees a doctor in a HSCRC regulated hospital outpatient clinic?**
    A. Covered services and billing policies are defined by MHA. 99211 is not a professional procedure code, billable on a CMS 1500 claim form, which has been deemed a covered service by MHA. UB04 claims for facility charges associated with outpatient clinic visits should include the corresponding HCPCS code with the appropriate Revenue Code.

12. **Q. On concurrent authorization reviews, will the ProviderConnect application remember information from the prior submission, such as Axis I-V Diagnoses, Medications, Individual Rehabilitation Plans (IRP) Goals, Progress, etc?**
    A. Upon transition, basic information will be transmitted to ValueOptions®. The first time you obtain authorization from ValueOptions®, you will need to enter information into the ValueOptions® system such as: medication, IRP goals and progress notes. If you need information from the APS system, it is recommended that you print or download before the transition. When additional authorizations are completed by ValueOptions®, the system will pre-populate certain data.

13. **Q. Once information is entered into ProviderConnect, will it be available to update upon subsequent reviews? (ex: IRP goals, progress)**
A. ValueOptions®'s system has the capacity to show past entry of clinical information and allow updates to progress, goals etc.

14. **Q. In the presentation, it was indicated that MHA & ValueOptions® would be developing clinical parameters for authorizations, would these differ in any way from the current guidelines? That is, will authorization criteria become more rigorous or, hopefully stay the same?**
A. ValueOptions® will follow MHA's direction. Authorization guidelines will not change unless directed by MHA.

15. **Q. In the presentation, uninsured eligibility was mentioned, but how will the ValueOptions® system handle authorization requests for new uninsured eligibility spans where the consumer does not currently have a temporary "grayzone" identification number?**
A. All open Uninsured Eligibility spans will transfer from APS to ValueOptions®. New Uninsured Eligibility spans can be requested on line or telephonically.

16. **Q. Will ProviderConnect be able to save data, prior to submission, so that Utilization Managers can review authorization requests before they are submitted to ValueOptions®?**
A. ValueOptions® is working internally to assess this capability through ProviderConnect. This feature will not be available on September 1, 2009. The date for this system change will be provided as soon as it is available.

17. **Q. Will we be able to maintain multiple users per registration in ProviderConnect?**
A. Providers will be able to obtain single or multiple logins based on the provider's administrative preference. Multiple logins can be obtained by contacting the ValueOptions® EDI helpdesk at 1-888-247-9311 Monday through Friday, 8:00am to 6:00pm EST.

18. **Q. How will we handle an authorization when, during the course of the inpatient stay, the child switches to "Long Term Care?"**
A. This will be a telephonic process with the dedicated Care Manager.

19. **Q. Can providers submit inpatient authorizations electronically or telephonically?**
A. All authorization requests can be submitted either electronically or telephonically, although providers are encouraged to use the electronic option.

20. **Q. If an authorization is submitted on August 31, will ValueOptions® handle these payments?**

A. APS will continue to accept authorizations for all levels of care through August 30, 2009, and through August 31, 2009 for inpatient, Residential Crisis Services (RCS) and Residential Treatment Centers (RTC) through August 31, 2009. ValueOptions® will begin accepting authorizations on September 1, 2009. Providers should request authorizations accordingly. Until further notice, ACS, APS' current claims vendor, has been contracted by ValueOptions® to continue to process claims for dates of service prior to September 1, 2009.

21 **Q. Will retroactive authorizations be granted?**

A. No, except in the case of retroactive consumer Medicaid eligibility, retroactive authorization will not be granted.

22**.** **Q. How many services will you authorize for a new consumer and is OMS part of this new system?**

A. The OMS system remains the same with some modifications to several questions. For OMS authorizations, generally, two and then 150 visits will be authorized. For non-OMS authorizations, the current number of authorization approved remains the same. E.g. 12 visits for initial outpatient, 13 for medication management.

23 **Q. In the current MAPS system, batches are posted twice a day that give a summary of authorizations and can be viewed or downloaded. Will this remain the same?**

A. You will have a similar capability, effective September 1, 2009.

24. **Q. Will CSAs have a separate training?**

A. Yes. CSA training began 8/21 and will continue through 8/28.

25. **Q. Will you be using the same Medicaid Provider Identification Numbers?**

A. We have received provider files from Medicaid, including provider Medicaid numbers, which will not change. However, claims will be paid based on the National Provider Identification (NPI) numbers.

26. **Q. Is there a template for questions that will be asked in telephonic reviews?**

A. Yes, we will provide this prior to September 1, 2009.

27. **Q. What is the retroactive review process for each level of care?**

A. The processes are not changing as a result of the transition.

28. **Q. Will hospitals with large volumes be assigned a dedicated reviewer/case manager?**
A. Yes, ValueOptions® believes strongly in the dedicated Case Management model.

29. **Q. What is the turnaround time for responses to authorization requests?**
A. The turnaround time requirements have not changed.

30**.** **Q. Where and how will the concept of recovery be worked into the ProviderConnect?**
A. A field has been added to ProviderConnect, i.e. "consumer's hope for recovery and resilience", and it is free text. There are other free text fields available to providers to document additional information.

31. **Q. How will we receive notification of an authorization denial?**
A. The provider will receive telephonic notification of the determination. Denial letters will be generated from the system and mailed to the provider, if the provider chooses this option. In addition, Authorization notification letters can also be viewed by the provider via ProviderConnect.

Billing/ Reimbursement:

1. **Q. Is a copy of the 837 Companion Guide available?**
A. All EDI companion guides are on the ValueOptions® website. From the "For Providers" tab, select "compliance" from the list of links on the left side of the screen. This is our generic companion guide. We do not yet know if we will need to customize it for Maryland. Customizations would only be done if necessary to meet MHA billing requirements.

2. **Q. With which clearinghouses does ValueOptions® contract?**
A. While ValueOptions® does not contract with clearinghouses, we do accept files from many of them. We require that all claims files be HIPAA compliant. Our technical requirements for any submitter, including third party vendors, are stated in our companion guide.

3. **Q. Will the hospitals be able to submit "test" claims prior to Sept. 1?**
A. Yes, providers need to contact our EDI Help Desk to arrange for testing. We recommend that you begin the testing process as soon as you receive your login and password.

4. **Q. Will this testing be end-to-end, including the return of an 835 file?**
A. The 835 is provided by our electronic funds transfer (EFT) vendor, PaySpan. You can contact them directly for their companion guide or

other assistance at 1-877-331-7154 or
providersupport@payspanhealth.com. .

5. **Q. What acknowledgment will providers receive after submitting an 837 file?**
   A. Two emails are sent to the submitter. The first is to acknowledge receipt of the file. The second email will advise if the file passed or failed HIPAA validation.

6. **Q. How will remittances be received?**
   A. You must register with PaySpan and can elect to receive Electronic Funds Transfer (EFT) payments or paper checks. You can also select to receive an electronic Provider Summary voucher via PaySpan or ProviderConnect.

7. **Q. Does Value Options® report both claim adjustment remark codes and remittance advice remark codes in their 835 files?**
   A. HIPAA requires specific remark codes which are the remarks in the 835. More explicit explanations are on the Provider Summary Voucher, or may be reviewed on line at the ValueOptions® website.

8. **Q. Is the ValueOptions® computer system designed to reimburse both unregulated and regulated (i.e., HSCRC) hospitals?**
   A. Yes

9. **Q. How are denials handled and what is the appeal process?**
   A. Claims denials are included in the Provider Summary Voucher and the 835. The rights to appeal and timeframes are governed by MHA and are not changing. These are defined in COMAR 10.09.70.

10. **Q. How will claims for patients with both medical and mental health services be handled (dual diagnosis)?**
    A. The process for processing these claims has not changed.

11. **Q. Are late charges billed with an XX5 (late charge only) or XX7 (all inclusive) UB bill type. Can late chares be billed electronically?**
    A. Specific guidelines will be forth coming.

12. Q. Can hospital providers bill multiple lines for the same room and board Revenue codes if there is a difference in room rates during a stay?
    A. Yes.

13. **Q. How are emergency department petition claims handled?**
    A. The process for Emergency Petitions will remain the same. The forms and instructions will be posted on the ValueOptions® website

14. **Q. If a provider is using a clearinghouse, can the 835 go directly to the provider, or must it go to the clearinghouse?**

A. The 835 is distributed by PaySpan, not ValueOptions®. Regardless of whether a provider submits claims directly, or through the use of a clearinghouse, the 835s can be sent directly through the provider via PaySpan. Per PaySpan, "Remittance details are delivered with each EFT payment, viewable online and downloadable in a HIPAA 835 format" (http://www.payspanhealth.com/ProviderFAQs.asp#7).

15. **Q. If providers are working through a clearing house will everything stay the same?**

A. Yes. If the clearing house can submit HIPAA compliant files.

16. **Q. May providers submit claims with dates of service prior to 9/1/2009 to ValueOptions® rather than ACS?**

A. No. Until further notice, providers should keep the (MAPS-MD)/ACS billing system in place and continue to submit claims to ACS for dates of service prior to 9/1/2009 and add ValueOptions® for claims for services after 9/1/2009.

17. **Q. Will nurses be paid for services rendered in the Emergency Department (ED) or Hospital?**

A. Psychiatric evaluations by Nurse Practitioners (NP) in an ED or on an inpatient unit are reimbursable by the PMHS. However, only a psychiatrist or a NP may be reimbursed for the evaluation. I.e. only one claim may be submitted for the evaluation for the same consumer on the same day.

18. **Q. Will there be an updated fee schedule?**

A. The fee schedule will remain the same unless notified by DHMH..

19. **Q. Will the timely filing requirement remain the same?**

A. Yes.

20. **Q. Will providers need to change billing software packages?**

A. No, as long as the current software creates HIPAA compliant 837 files the provider will not have to update their software. The ValueOptions® 837 companion guide can be located on the provider section of our website www.valueoptions.com under the compliance link on the left.

21. **Q. Will the payment cycle remain the same, i.e., will claims submitted by close of business (COB), Thursday, be paid the following week? Also, will Thursday remain the official cut-off day for claim submission?**

A. ValueOptions® will run the claims posting cycle on Tuesday and the EFT payment will occur on Thursdays. Clean claims submitted by Monday COB will be processed on Tuesday.

22. **Q. Can providers download provider summary vouchers?**
    A. No. However, summary vouchers can be printed from either ProviderConnect or PaySpan.

23**. Q. If providers are submitting paper claims, should they continue?**
    A. ValueOptions® would like for providers to submit claims electronically through ProviderConnect. However, we can accommodate paper claims.

24**. Q. Can providers use the same website for Medicaid and ValueOption® commercial claims?**
    A. Yes.

25. **Q. Can claims be electronically adjusted?**
    A. Currently, incorrectly submitted claims can be voided and resubmitted electronically if the provider identifies an error prior to submission. A system upgrade is in development which will allow providers to submit corrected claims, post processing, and upload supporting documentation.

26. **Q. If claims that are already in process have not been responded to by 9/1, will they transfer over to ValueOptions®?**
    A. Until further notice, all claims for dates of service prior to 9/1/2009 will be processed by ACS, the current claims vendor for MAPS-MD.

27. **Q. Will ValueOptions® have a P.O. Box for secondary claims?**
    A. Yes.

VO/Maryland MHA Claims
PO Box 1950
Latham, NY 12110.

28. **Q. When providers submit the Psychiatric Rehabilitation Program (PRP) encounter data, the MAPS system required them to enter a dollar amount. Providers were advised to enter $1 per encounter. How will the ValueOptions® system process the PRP encounter data submitted under procedure code H2016?**
    A. PRP Providers should continue to submit the encounters with a $1 charge per encounter.

29**. Q. What is the process for returning overpayments? May we send a check or will repayment be withheld from future payments?**
    A. Providers should contact Customer Service to report the overpayment. If the provider chooses to refund the overpayment by check, the check must be accompanied by the Provider Summary Voucher, with the claim resulting in the overpayment clearly identified. If the provider prefers to

repay the overpayment by withholding payment for future claims, Customer Services will assist with arranging the withhold process.

30. **Q. What is the process for billing for dually eligible Medicare/Medicaid consumers?**
    A. The process has not changed. For services covered by Medicare, Medicare is the primary payor and Medicaid is the secondary payor. These claims are not processed by ValueOptions®, but are processed by directly by Medicare/Medicaid. For services not covered by Medicare, such as Psychiatric Rehabilitation Programs (PRP), claims may be sent directly to ValueOptions®. For services provided by clinicians not recognized by Medicare, e.g. Licensed Clinical Professional Counselors (LCPC), providers should bill Medicare "incident to" whenever possible. Independent, i.e. on-Outpatient Mental Health Center (OMHC) LCPCs who cannot bill "incident to" may submit claims directly to ValueOptions® and Medicaid will reimburse as primary.

31 **Q. What Provider Identification Numbers should be submitted on the 837 file?**
    A. Provider Tax Identification Number (TIN) or Employer Identification Number (EIN) and the National Provider Identification Number (NPI) should be submitted. The Provider's Legacy (i.e. Medicaid Provider Number) should <u>not</u> be submitted on the 837.

31. Q. **Can multiple lines (for separate dates of service) be billed on a UB-04 for hospital outpatient clinic services, or must each date of service bill billed on a separate claim form?**
    A. Providers may bill multiple lines (for each date of service) on a single UB-4 claims form.

Appeals:

1. **Q. How are appeals in progress going to be handled?**
   A. MAPS will continue to process appeals/grievance received prior to August 15, 2008, after which they will stop accepting new appeals for all services, except inpatient, Residential Treatment Centers (RTC) and Residential Crisis Services (RCS).

2. **Q. What is the process for claims resolution for services rendered prior to September 1st?**
   A. Until further notice, ACS will continue to resolve claims issues for dates of service prior to September 1, 2009. ACS Claims Customer Service can be reached at 1-800-888-1965, before and after September 1, 2009.

3. Q. **Who will process claims for patients whose stay includes days before and after September 1st?**

A. ValueOptions®.

4. **Q. How does the claims appeal process work?**
   A. The appeal process is not decided by ValueOptions®. The requirements for appeals will stay the same.

Administrative Issues:

1. **Q. Will hospitals be given a provider relations representative, or a listing of contact names and numbers, for authorization, claims and retraction issues?**
   A. Maryland providers will have several Provider Relations representatives to provide assistance. Providers can reach a provider representative by calling the same 800 number as they currently use to reach MAPS. The 1-800-888-1965 number will be operated by ValueOptions® beginning September 1, 2009.

2. **Q. Has ValueOptions® developed a backup plan for communication backlog, especially during the first few weeks of the transition?**
   A. We are working with MHA to ensure that providers are given all information in order ensure a smooth transition. ValueOptions® will have national resources available during the transition.

3. Q. **Will providers be able to request Uninsured Eligibility online, effective 9/1/2009?**
   A. No. Uninsured Eligibility requests will be accepted telephonically until all the criteria is finalized and programmed into CareConnect, the ValueOptions® utilization management system.

Miscellaneous:

1. **Q. Will consumers be able to have partial benefits from different providers at the same time?**
   A. The rules governing authorizations and payment for services remain the same.

2. **Q. Will Case Management services change or remain the same?**
   A. MHA has revised the process for Case Management from contractual to Fee for Service, effective September 1, 2009. Webinar training for Case Management providers has been scheduled for September 9. The CSAs have received information about registering for training and will be contacting their contracted Case Management providers.

3. **Q. Are emergency funds available to support providers?**
   A. MHA's goal is for a smooth transition.

4. **Q. Will there be training for providers regarding the ValueOptions® online processes?**
   A. The initial webinar training sessions were completed the week of August 17. Face-to-face clinical training is scheduled for August 27. (see *http://www.valueoptions.com/providers/Training.htm* for registration information.) Additional Claims/EFT and clinical trainings will be scheduled in September. In the interim, if you would like a copy of the PowerPoint presentations for one or more of the clinical trainings (OMS Providers, Non-OMS Providers, High Level of Care Providers) or the Claims/EFT training, please contact Nancy Calvert at nancy.calvert@valueoptions.com. The PowerPoint presentations will also be posted on the ValueOptions®, Maryland website.

5. **Q. Will clinicians have access to the ValueOptions® system?**
   A. Clinicians and administrative staff will have access. Any network provider registered in ProviderConnect will be able to view information about consumers in their care.

6. **Q. Will ValueOptions® be able to provide data or case reports?**
   A. There are many reports that ValueOptions® will be delivering to MHA and together, we will review the reports and data that can be shared with providers.

7. **Q. Is it possible to edit the billing system so patient coordinators can view only authorizations?**
   A. No. However, depending on the provider set-up in ProviderConnect, access can be limited by practice location.

8. **Q. Will the sections or elements in ProviderConnect meet state requirements?**
   A. Yes. All required elements are being designed based on COMAR, MHA regulations.

9. **Q. How soon can we register for ProviderConnect? Do we have to wait until 9/1?**

   A. As of August 15, all Maryland PMHS Medicaid providers could begin to register for ProviderConnect. Additional information regarding the ProviderConnect registration process is currently posted to the MHA website. http://dhmh.state.md.us/mha/transitiontovalueoptions.html Please refer to the document titled "ProviderConnect Registration Letter", dated August 17, 2009.

10. **Q. Do you have to be a participating provider with ValueOptions® to register in ProviderConnect, or will a provider file be downloaded from Medicaid?**

A. You do not need to be a commercial, participating ValueOptions® provider to register in Provider Connect. However, providers do need to in the ValueOptions® system in order to register. Provider file information has been received from MMIS II (Medicaid's database) and ValueOptions® is in the process of loading the information into our system.

11. **Q. On the ValueOptions® website, there is an inbox for messages. Will providers be able to submit inquiries electronically?**

A. Yes, there are several places within ProviderConnect where you can submit inquires. The most frequent places where inquiries are submitted are through the authorization "search" and the claims status "search" functions.

12**. Q. How often will patient information be updated?**

A. ValueOptions® will be receiving a daily consumer eligibility file from Medicaid.

13.**Q. If we have one user ID in ProviderConnect, can multiple users be signed on at the same time?**

A. Yes

14. **Q. Will consumers be issued new Identification Cards?**

A. No.

15. **Q. May Uninsured Eligibility requests be backdated?**

A. In general, Uninsured Eligibility requests may not be backdated. However, MHA allows a 30 day grace period for requesting uninsured eligibility if a consumer is in active treatment, has an open authorization, and loses Medicaid Eligibility. As with all Uninsured Eligible consumers, the provider is expected to assist the consumer in obtaining Medicaid eligibility