ValueOptions® Maryland

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FAQ (Frequently Asked Questions)

August 5, 2009

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

Authorizations:

Q. Do current authorizations expire on August 31 or will they be extended?
A. No. Any authorization issued by APS will be honored by ValueOptions®. The authorization dates will transfer from APS to ValueOptions®.

Q. Will blanket authorizations be given?
A. No

Q. What is the procedure for after hours authorizations?
A. ValueOptions® has 24/7 telephone coverage with Maryland Licensed Care Managers.

Q. What is the authorization process for lower levels of care—crisis beds, dual diagnosis substance, abuse programs, PHP, IOP, and OP?
A. Authorization processes and procedures are not changing.

Q. When a verbal authorization has been given, will a written communication follow?
A. Yes, letters will be generated and issued to consumers and providers.

Q. How will adoption cases be handled- will there be issues with names and new MA numbers and Social Security numbers?
A. We have not worked through the details for this process yet, however, our expectation is that we will replicate the current process. We understand that these children will be assigned new ID numbers. We will link the new ID to the old ID within our system so that we can find the eligibility and history using either ID.

Q. What is the process for obtaining additional units if used prior to the authorization expiration date?

A. Processes and procedures are not changing. All levels of care require pre-authorization except emergency treatment. Requests for additional units can be submitted on line or by telephonic review.

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.

Q. Will one authorization cover both facility and provider? For both IP and OP visits?
A. Yes one professional service can be billed for each IPMH day.

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

Q. How will the DES 1000/ long-term span process be handled?
A. Same as now.

Q. What would the procedures be to obtain authorization for Respite and PRP?
A. Respite and PRP authorizations can be requested on line or via telephonic review.

Q. Does ValueOptions® accept E&M codes for any services, specifically 99211 to be used when the patient sees a doctor in hospital space?
A. Covered services and billing policies are defined by MHA. 99211 is not a procedure code that has been deemed a covered service by MHA.

Q. On concurrent authorization reviews, will the ProviderConnect program remember information from the prior submission such as Axis I-V Diagnosis, Medications, 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 intoValueOptions®’s 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.

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.

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.

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 information will transfer. When the system is set up instructions will be provided for uninsured eligibility.

Q. Has there been progress on the ability for ProviderConnect to save data, 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 implementation will be provided later

Q. Will we be able to maintain multiple users per enrollment like we've done in APS CareConnection®?

A. Providers will be able to obtain a 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 thru Friday, 8:00 am to 6:00 pm EST.

Q. How will we handle an authorization when, during the course of the IP stay, the child switches to "Long Term Care?"

A. This will be a telephonic process with the dedicated Care Manager.

Q. How does a provider submit inpatient authorizations?

A. Providers can submit requests for inpatient authorizations through ProviderConnect or via telephone review.

Q. Will providers get an acknowledgement when submitting authorizations?

A. An acknowledgement will appear as soon as the provider submits the authorization via ProviderConnect. From that acknowledgement screen providers have the option to print the authorization.

Q. Can providers submit inpatient authorizations electronically or telephonically?

A. Providers can submit authorizations both electronically and telephonically. Although providers are encouraged to use the electronic option.

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

A. Yes.

Q. MAPD-MD authorizations are 24 hours, will this stay the same?
A. Yes.

Q. Will retroactive authorizations be granted?
A. No, except in the case of retroactive consumer Medicaid eligibility, retroactive authorizations are will not be granted.

Q. Will ValueOptions® be doing verbal authorizations off site?
A. 24/7 licensed staff members will be available to take the reviews by telephone, based on the level of care.

Q. How many services will you authorize for a new consumer and is OMS part of this new system?
A. Yes, the OMS system remains the same with some modifications to several questions. How many sessions? Generally, two and then 150. There are no changes to the existing process.

Q. For authorizations that start on 9/11-11/1, if you get the authorization on 11/5, will the input date of 11/5 be approved?
A. We are still working out the details with the transition team.

Q. Current MAPS system: Batches are posted twice a day that provide a summary of authorizations and can be viewed or downloaded. Will this remain the same?
A. You will have a similar capacity effective September 1, 2009.

Q. Will CSAs have a separate training?
A. Yes. The trainings have been scheduled and distributed to the CSA Directors.

Q. Will all of the authorization and treatment planning information from MAPS transfer?
A. Most information will transfer,with the exception of free text narrative, treatment plans, etc. Please copy your treatment plan information.

Q. Will you be using the same Medicaid ID numbers etc?
A. We will receive files from MAPS and MA. We will use your current NPI.

Q. Do you do an 835 transaction?
A. Yes you can sign up with PaySpan to get an 835.

Q. Currently uninsured eligibility requests are done telephonically. What is the ValueOptions® process for requesting uninsured eligibility?
A. We have the technology to allow provider to request eligility on line, which is our preference. However we will also have telephonic process.

Q. Since ValueOptions® accepts both web based and telephonic request for authorization, can a provider choose to use only Web based process?
A. Yes.

Q. What type of review is required for each level?
A. Either telephonic or on line requests.

Q. Is there a template for questions that will be asked in telephonic reviews?
A. Yes, we will provide this as part of the clinical training.

Q. What is the retroactive review process for each level of care?
A. The processes are not changing as a result of the transition.

Q. Are Internet reviews permitted for any level of care?
A. Yes, all levels can be entered on line;. If auto-approval is allowed, we will issue an authorization in real time.

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

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

Q. Where and how will the concept of recovery be worked into the ProviderConnect Plan?
A. A field has been added to ProviderConnect re: "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.

Q. When an authorization request has been entered in ProviderConnect, will the information pre-populate a continued authorization request?
A. Yes, the information will pre-populate the continuing authorization request, except for fields identified by MHA as requiring re-entry.

Q. How will we receive notification of an authorization approval or denial?
A. The provider will be notified by telephone of the determination and 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:

Q. Does ValueOptions® have an 837 Companion Guide?
A. Yes.

Q. How do we get a copy of the 837 Companion Guide?
A. All EDI companion guides are on the ValueOptions® Web site under 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.

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.

Q. Will the hospitals be able to submit "test" claims prior to September 1?
A. Yes, they 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.

Q. Will this testing be end-to-end including the return of an 835 file?
A. No, our 835 is provided by our electronic funds transfer vendor, PaySpan. You can contact them directly for their companion guide.

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.

Q. How will remittances be received. Is it a transition from Emdeon?
A. You must register with PaySpan and can elect to receive EFT payments. You can also select to receive an 835 or mailed voucher.

Q. Does ValueOptions® 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® Web site.

Q. Is the ValueOptions® computer system designed to reimburse both "non-waiver" and waiver (i.e., HSCRC rates) hospitals?
A. Yes.

Q. How are denials handled and what is the appeal process?

A. Claims denials are included in the Provider Summary Voucher and 835. The rights to appeal and timeframes are governed by MHA and are not changing. These are defined in 10.09.70.

Q. How will claims for patients with both medical and mental health services be handled (dual diagnosis)?
A. Same as current.

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

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? If not, how are these billed?
A. Specific guidelines will be forth coming.

Q. How are emergency department petition claims handled? Are all charges included or just the ED Revenue Codes? Are they billed to a specific address? Is SSN used as the member ID, since these patients don't have Medicaid numbers?
A. Specific guidelines will be forth coming.

Q. If a PV is using a clearinghouse, can the 835 go directly to the PV or must it go to the clearinghouse?
A. The 835 is distributed by PaySpan, not ValueOptions®. Regardless of whether providers submit claims themselves, or through the use of a clearinghouse, the 835s can be sent directly to providers via PaySpan. Per the PaySpan FAQ page, "remittance details are delivered with each EFT payment, viewable online and downloadable in a HIPAA 835 format" (http://www.payspanhealth.com/ProviderFAQs.asp#7).

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

Q. May providers submit claims with dates of service prior to 9/1/2009 to ValueOptions® rather than ACS?
A. No. Providers should keep the (MAPS-MD)/ACS billing system in place and continue to submit claims for dates of service prior to 9/1/2009 until further notice and add ValueOptions® for claims for services after 9/1/2009.

Q. Will nurses be paid for services rendered in the ER/Hospital?
A. Psychiatric evaluations by Nurse Practitioners in an ED or on an inpatient unit are reimbursable by the PMHS. However, it is either a psychiatrist or a NP

performing the evaluation. Only one claim may be submitted on the same day not both.

Q. Will there be an updated fee schedule?
A. The fee schedule will remain the same unless notified by DHMH.

Q. Will the timely filing requirement remain the same?
A. Yes.

Q. Will providers need to change billing software packages?
A. No, as long as the current software creates HIPAA compliant 837 files providers will not have to update their software. The ValueOptions® 837 companion guide can be located on the provider section of our Web site www.valueoptions.com under the compliance link on the left.

Q. Will the payment cycle remain the same, i.e., will claims submitted by 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 will occur on Thursdays.

Appeals:

Q. How are appeals in progress going to be handled?
A. MAPS will complete these prior to the transition date. They will stop accepting new appeals for all other services except inpatient, RTC and residential crisis on August 15, 2009.

Q. What is the process for claims resolution for services rendered prior to September 1st?
A. ValueOptions® will continue the process.

Q. Who will process claims for patients whose stay includes days before and after September 1st?
A. ValueOptions®.

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

Administrative Issues:

Q. Will Hospitals be given a “provider relations” representative or a listing of contact names and numbers for authorization, claims and retractions?

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.

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.

Miscellaneous:

Q. Can providers download provider summary vouchers?
A. No. However, summary vouchers can be printed.

Q. Will consumers be able to have partial benefits from different providers at the same time?
The rules governing authorizations and payment for services remain the same. If there is a particular situation we will need further detail.

Q. Regarding Fee for Service case management, will that service be the same or change?
A. MHA is currently revising the process for case management. It will be changing from contracts to Fee for Service beginning September 1, 2009. Additional information will be provided shortly, outlining the details.

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

Q. Will there be additional training for providers regarding inpatient electronic process?
A. Yes. Training has been scheduled and is posted on MHA's website, www.mha.state.md.us/mha and the MAPS-MD website, www.maps-md.com.

Q. Will Clinicians have access to ValueOptions® system?
A. Clinicians and administrative staff will have access.

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

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.

Q. Who can view what is in the system?
A. Any network provider will have access to view information about consumers in their care in ProviderConnect.

Q. If client comes in on a holiday, will a provider still get through?
A. Yes, Maryland Licensed Care Managers are on call at all times.

Q. If providers are submitting paper claims should they continue?
A. ValueOptions® would like for providers to submit claims online. However, the system can accommodate paper claims.

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

Q. If providers need to have a claim adjusted, can it be electronically adjusted?
A. Providers may upload related documentation as in the demo. Details are discussed in the scheduled Claims/EFT trainings.

Q. Claims that are already in process that 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 claims vendor for MAPS-MD.

Q. Is it possible to edit the billing system so patient coordinators can only view authorizations?
A. Yes.

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

Q. How soon can we register for ProviderConnect? Do we have to wait until 9/1?
A. In order to register for ProviderConnect, ValueOptions® must have your provider file data in our system. Information on registration is posted on MHA's web site www.dhmh.state.md.us/mha

Q. Will you have to be a participating provider with ValueOptions® or will a file be downloaded from MAPS?
A. Your provider file data is being provided by Medicaid and will load into the ValueOptions® system.

Q. On the Web site there is an inbox for messages, will providers be able to submit inquiries?

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

Q. How often will patient information be updated?

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