March 2011

ValueOptions Colorado Medicaid Provider News

New Psychological Testing Referral Form

Psychological testing involves the administration and interpretation of standardized psychological instruments to assess an individual's emotional, behavioral, or cognitive functioning. Psychological testing is an outpatient service that must be pre-authorized. Testing is always considered a routine service, and requests for testing must be determined within a ten (10) calendar-day period. Testing is approved only after traditional interviewing and treatment approaches have proven ineffective.

Requests for psychological testing must be made in writing by completing the "Psychological Testing Request Form." This form has been revised recently to elicit more specific information about the need for testing services. The form requires the treating provider or referral source to list the reasons why testing is necessary and the specific questions the testing is meant to resolve. As a reminder, testing that is solely for legal purposes, school placement, or treatment of a non-covered diagnosis will be denied in most instances for failing to meet the established criteria for medical necessity. Providers may want to review the level of care guideline, "Psychological and Neuropsychological Testing," to understand the most common reasons for denial.

To obtain a copy of the new form, please visit the BHO website or request a fax/electronic copy by calling the ValueOptions Service Center at 1-800-5008 and selecting the "inpatient" option to speak to clinical staff member.

TOOLS AVAILABLE ON THE WEB

Visit www.valueoptions.com and link to the Network Specific websites to use any of the following web-based tools for providers:

- Clinical Guidelines
- Member Handbooks
- Provider Handbooks
- Covered Diagnosis List
- Treatment Outcome Tools
- Colorado Medicaid Provider Manual
- Health Alert Member Reminder Calls
- Member Rights and OMBUDSMAN Posters
- ProviderConnect and Direct Claims Submission
- CCAR Online Application and Member Handout

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COLORADO CLIENT ASSESSMENT RECORD (CCAR) NEWS

As a Colorado Medicaid provider, you know the requirements to submit a CCAR form for every admission, for the annual update and again upon member discharge. Did you know, however, that this requirement applies to all providers seeking reimbursement for mental health services from any state funding source (i.e Medicare or Medicaid).

You may have recently received a letter from ValueOptions Colorado Partnerships indicating lack of compliance with CCAR submission requirements. If you have received payment for treatment of a Medicaid client, you must submit a CCAR.

Providers failing to submit these forms are at risk of payments being withheld by ValueOptions until CCARs are submitted for all Medicaid clients.

Please contact Provider Relations if you are having any trouble submitting CCAR forms. We are here to help you in anyway that we can. Call 1-800-804-5040 or email us at COProviderRelations@valueoptions.com to get your questions answered.

CLAIMS SUBMISSION

Colorado Medicaid Claims should be sent to:

ValueOptions

PO Box 12698

Norfolk, VA 23502

ATTN: Colorado Medicaid Claims

We are still seeing a number of claims come to the Colorado Service Center and have started to return these claims to providers.

Please make this change with your billing departments and claims processors to avoid delays in your claims payments.

Another way to avoid having claims returned to you is to use the ProviderConnect online provider application. ProviderConnect includes a Direct Claims Submission system which is an online application to submit your claims. Typically, when clean claims are submitted through ProviderConnect, provider payment turn-around is less than a week.

Change in State Regulations Affecting Grievances and Appeals

Recently, the State of Colorado Department of Health Care Policy and Financing made changes to the Code of Colorado Regulation 10 CCR 2505-10 8.200 MEDICAL ASSISTANCE - SECTION 8.200 regarding the timeframe in which Medicaid members have to file a grievance or an appeal to a Notice of Action. The following changes became effective as of November 31, 2010:

- Medicaid members shall have thirty (30) calendar days to file a grievance or complaint from the date the incident occurred (they previously had 20 days);
- An appeal may be implemented at the member's request within thirty (30) calendar days of the date of a Notice of Action (formerly 20 days); and
- A state fair hearing may be filed by the member within thirty (30) calendar days of the date of a Notice of Action (changed from 20 days).

Notification of these changes are being sent to current Medicaid members eligible under Colorado Health Partnerships, Foothills Behavioral Health Partners, and Northeast Behavioral Health Partnership through an annual letter. An addendum letter will accompany Member Handbook mailings to members who are newly eligible. Updated copies of the Member Handbooks with these changes will be available early in 2011.

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Facility Corner:

Billing for Psychiatric Diagnosis When Member is on a Medical Floor

If the principal diagnosis is mental health related and covered under the BHO contract but the client also received physical health services, one bill should be issued for the entire hospitalization and paid through the BHO, as the BHO is obligated to pay for all services provided in the hospital between admission and discharge, provided that the client is an enrolled member in the BHO.

If the principal diagnosis is mental health related, the hospital will need to follow all BHO billing processes, including prior authorization, to ensure payment.

At the point when mental health is determined to be the primary reason for hospitalization, the prior authorization process must be followed at once. The hospital is at risk of not being reimbursed for the services provided if BHO covered services are not billed in accordance with BHO policies and procedures. The determination of the principal diagnosis is made by an attending physician, but is subject to review by the Department, the Department's agents, federal auditors, and the BHO.

Billing for Psychiatric Consults

ValueOptions' Colorado Partnership BHOs have been working with consulting physicians who perform inpatient consultations for members while they are on an inpatient unit.

When performing a consult service, physicians should bill the BHO for the consultation with a BHO covered diagnosis. These services will be paid for without authorization for up to 4 units. If additional services will be required, please contact our Access to Care Line to obtain authorization .

Introducing the New SID Team!

Systems Integration

The Systems Integration Department is a new department at ValueOptions Colorado. The department acts as a resource and liaison between external and internal customers to ensure the consistent delivery of quality behavioral health services in accordance with contractual agreements and governmental and regulatory agency guidelines to maximize care coordination and continuity of care through work with other agencies

The Department interfaces with community and state agencies and members in dynamic collaboration to foster efficient use of resources and to educate members and providers on best practices in the provision and utilization of behavioral health care. The Department consists of a Director, Charlotte Yianakopulos-Veatch, Ph.D., an Education Coordinator, Paul Baranek LPC, and two Field Care Managers, Vicki Linden LPC and Deb Keairnes LPC.

Field Care Managers attend staffings and manage facilities and complex cases for all ValueOptions Colorado areas. They collaborate with community agencies to achieve common goals in the delivery of behavioral health services. The Education Coordinator assesses training needs throughout the Colorado Health Partnerships BHO and arranges and provides for training and informational resources.

A prominent current Department project is promoting integrated care efforts throughout the region in accordance with rapidly unfolding national health care reform. How might this affect you? In order to move toward coordinating care and treating the whole person you might use the Systems Integration Department to identify resources for a member with Spina Bifida, hearing impairment or a traumatic brain injury and mental health issues. For more information on Systems Integration Department services contact (800) 804-5040 and ask for Paul Baranek, Debbie Keairnes or Vicki Linden. For a quick overview of integrated care as it relates to behavioral health visit this website: http://www.integratedprimarycare.com/inpractice.htm

Compliance Corner

As we move into the New Year, it ' s becoming more critical than ever that as a provider, you know the basic requirements for medical record documentation. Federal and state efforts continue to focus on medical record compliance audits and the identification of fraud, waste and abuse through these audits. At ValueOptions, medical record audits and educational efforts continue as part of our plan for compliance with federal and state regulation. In January, we began to request repayment of paid claims when a medical record note is missing for a paid claim. In addition, missing required documentation elements will result in requests for corrective action plans. Supporting educational materials will be provided.

The medical record provides evidence that services were provided to a member; records pertinent facts, findings, and observations about an individual ' s medical history, treatment, and outcomes; and facilitates coordination and continuity of care. *Please review the required documentation elements and ensure your medical records contain this information!* *Cont on page 4.*

Compliance Corner Continued from page 3:

- Start and Stop Times: Every billable activity must have a service start time and stop time that matches the time billed
- Service Codes: Service codes submitted with claims for payment must match the documentation in the medical record
- Individualized Progress Notes: Notes must be specific to the members, appropriately support the time, type, etc. of services billed and tie back to the member's treatment plan. The members' names must be included on all notes
- Units Billed: Number of units billed must match number of units in documented
- Full Signatures with Credentials and Dates: All documentation and progress notes must be signed and include credentials
- Covered vs. Non-Covered Services: Services provided to the member must be covered and billable
- Service Definitions: Services provided/documented must meet the service definition for the specific code billed. All documentation must be legible. Amendments: All changes must be initialed and dated, with single strike-through line made throughout changed documentation.

Comprehensive documentation training will be available later this year through ValueOptions. Providers will be notified of the date and format of the training. Plan on attending to learn more.

Using Interpreter Services and Language Specialties

Did you know that providers can access interpreter services through ValueOptions?

ValueOptions can help you to facilitate phone calls and member outpatient sessions where the member needs an interpreter. If you have a member in your care who needs an interpreter for American Sign Language, Spanish, English, Russian or Swahili, ValueOptions can help.

To access these services, please contact our Access to Care Lines listed below. A Care Manager or a Clinical Services Assistant will be happy to assist you.

Access to Care Standards for Inpatient and Residential Services

The requirements around availability of providers after a client has been discharged from residential or inpatient services include:

Outpatient follow-up appointments are required within seven (7) business days after discharge from an inpatient psychiatric hospitalization.

Outpatient follow-up appointments or equivalent post-discharge follow-up are required, documented in the discharge care plan, within seven (7) business days after discharge from a residential treatment facility.

CONTACTING VALUEOPTIONS COLORADO PARTNERSHIP BEHAVIORAL HEALTH ORGANIZATIONS:

ValueOptions Colorado Service Center Administration:	1-800-804-5040
Colorado Health Partnerships:	1-800-804-5008
Foothills Behavioral Health Partners:	1-866-245-1959
Northeast Behavioral Health Partnership:	1-888-296-5827

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