

**MANAGED CARE
SUMMARY INFORMATION
JULY 2009**

**Unless otherwise indicated, the information contained in this handout
pertains to the New York Downstate Geographic Area.**

**OASAS MANAGED CARE FORUM
WEDNESDAY, JULY 29, 2009**

HOW TO CONTRACT

Our system at Seaford is quite large, a 90-bed inpatient and detox facility and 5 outpatient locations offering clinic services (individual sessions and group sessions), IOP, and medication management. It's very important that when I negotiate or re-negotiate a contract, I have the correct information and if I have any questions, ask for clarification or confirmation of a specific policy or procedure.

Before you contact a managed care company, I would recommend that you access their website and learn as much about the company as you can. You can obtain information about the company and possibly their guidelines and/or criteria, etc.

If you do not have a contact name, call the provider relations department and ask to speak with someone who handles the New York area in their contracting department. If you cannot get a name, you may have to leave a message with provider relations to forward. If you do not hear from someone within a week, **CALL AGAIN.**

I would suggest that you first write an outline of the services you have to offer and the questions you want to ask.

- a) Know what you have to offer
 - b) List a rate for each type of service you provide (this is just for your benefit – do not discuss specific rates over the telephone; indicate that you will be sending a written proposal to their attention.)
 - c) If you are currently contracted with a managed care company, use those rates as a guide. Propose rates that are higher than you would accept; remember the contracting person will probably make a counter offer and you want a built-in buffer.
 - d) Ask about billing procedures and their billing address; e.g., what billing forms should be used and do they want Revenue Codes in addition to CPT codes.
 - e) Find out the name of their preferred lab. Is UDS covered under the member's medical insurance and how is the UDS billed. It may be considered inclusive.
 - f) Ask if any documents should be included with your proposal; e.g., your current OASAS Operating Certificate, JCAHO Accreditation, Professional Liability Face Sheet, W9, Staff Roster, etc.
- When you are negotiating a facility contract with a managed care company, you need to sell your facility. However, there is a fine line between being an aggressive negotiator and a pushy negotiator.
 - Remember you want to contract as a Facility for all services. However, a few of the managed care companies require that LCSWs are the only clinicians who may provide clinic level of care and insist that they be contracted or individually credentialed with the company. Try your very best to add clinic level of care as covered services under your facility contract.

- It's very important that all rate proposals should be in writing – either mail the proposal or scan and email the document including required attachments if that is acceptable. If the contracting person submits a counter proposal by telephone and it's agreed upon, send an email accepting the counter offer and list the agreed upon rates and, of course, it goes without saying that you should keep copies of each applicable document.
- In addition, it's very important to develop a good relationship with your contacts at managed care companies. You will find that your contact will be more willing to help resolve contractual issues when their relationship with you is a good one and in turn, they may call upon you to assist them. In addition, when you are re-negotiating your contract, you may find them more receptive. If the managed care company has an office near you, offer to conduct a clinical in-service for their care managers at their office and possibly take your contact out to lunch. We recently did an in-service at ValueOptions that was very well received and when I met three of my contacts there, it was hugs all around.
- After your contractual relationship has been in place for a while, some companies may negotiate a 3-year contract with automatic increases based on a percentage. You may want to inquire about that type of Contract, however, if you do negotiate a 3-year contract with automatic increases, you must contact the company to re-negotiate prior to expiration of the last increase.

I have developed a Managed Care Summary Information packet including the names of contracting contacts and sample rate proposal letters for your review and future reference and I hope you will find the information useful, but keep in mind that staff changes happen quite frequently and your contact person may change often.

**SAMPLE RATE PROPOSAL LETTER
TO NEGOTIATE FACILITY CONTRACT**

Date

Contract Contact Name
Name of Company
Address

Dear Name:

Per our telephone conversation Last Week or on Day/Date to discuss contracting as a facility with Name of Managed Care Company, listed below is my rate proposal for your review and consideration. **Insert information about your facility, e.g., licensed by OASAS, Agency Certification, number of locations, and services provided. Include a statement about the quality of your services and if you are currently treating members of their patient panel, mention that it would be more cost effective if you were a participating provider.**

Service

Proposed Rate

List of Services and Rates

I will follow up with you within the next two weeks to discuss further and if you have any questions or require additional information before our next conversation, do not hesitate to contact me at Your Telephone Number or email me at Your Email Address.

Thank you.

Your Name
Title

**SAMPLE RATE PROPOSAL LETTER
TO RE-NEGOTIATE FACILITY CONTRACT**

Date

Contract Contact Name
Name of Company
Address

Dear Name:

Per our telephone conversation, listed below are Name of Managed Care Company current rates and my rate proposal for Name of Facility for your review and consideration. Our current contracted rates with Name of Managed Care Company have been in effect since Year and I am sure that you are aware of the significant financial increases over the last year or past few years to provide quality inpatient and outpatient substance abuse services.

| <u>Service</u> | <u>Current Rate</u> | <u>Proposed Rate</u> |
|----------------|---------------------|----------------------|
|----------------|---------------------|----------------------|

List of Services and Rates

I will follow up with you within the next few weeks to discuss further and if you have any questions or require additional information prior to our next conversation, do not hesitate to contact me at Your Telephone Number or email me at Your Email Address.

Thank you.

Sincerely,

Your Name
Title

CPT Codes

90801 – Evaluation/Assessment

90806 – Individual Session

90846 – Family Session Without the Client

90847 – Family Session With the Client

90853 – Group Session

90862 – Medication Management (provided by a MD or NPP)

IOP usually requires a Revenue Code (906) and sometimes may require both a CPT code (90857) and a Revenue Code. Follow the guidelines required by the managed care company.

Inpatient Rehab is billed on a UB4 with Revenue Code 128

Every Facility is required to obtain a National Provider Identifier (NPI) number that must be indicated on your billing. You may apply for this number online at <https://nppes.cms.hhs.gov>. The process takes between 15 and 20 minutes.

NPI information is also available on most managed care websites.

AETNA

- No pre-cert is required for clinic level of care, however benefits must be verified regarding the specific number of clinic level visits. Aetna's required length of a group (90853) session is approximately 1 hour.
- 90801 is considered inclusive and not reimbursable when admit is to a higher level of care, e.g., IOP or inpatient.
- Authorization is required for IOP prior to providing service; however, Aetna will automatically grant authorization for 18 IOP sessions. If additional sessions are necessary beyond the initial authorized 18, contact Aetna to obtain authorization for the additional sessions.
- IOP Criteria – a minimum of 2 hours per day or 6 hours per week. Could include group, individual, or family.
- Client may self-pay – ask for expedited appeal and if client is in treatment, request a Doctor-to-Doctor conference call. If the client has exhausted his or her benefits, an appeal is not required.
- Website Address – www.aetna.com

BEACON HEALTH STRATEGIES

Medicaid lines of business – Affinity and Neighborhood Health Providers (NHP)

Affinity Health Plans include Medicaid, Family Health Plus (FHP) and Child Health Plus (CHP)

- No co-pays for outpatient services
- IOP requires authorization
- Members may self refer. The first 20 therapy sessions (Initial Encounters) require no prior authorization, but are subject to medical necessity. Registration prior to treatment is not required, however, confirmation of eligibility and benefits are extremely important to determine if a client has used a portion or all of his/her first 20 visits.
- There is a combined total of 60 mental health and substance abuse visits per calendar year allowed for FHP and CHP and all mental health and substance abuse visits count against the initial 20 visits.

Neighborhood Health Providers includes Suffolk Health Plan (SHP) and as of April 1, 2009, the New York Presbyterian Community Health Plan (NYPCHP), Medicaid, Family Health Plus (FHP) and Child Health Plus (CHP)

- Prior Authorization Required for the following services:
 - Inpatient Services
 - Inpatient Acute Substance Abuse Rehabilitation
 - Detox
- The initial Substance Assessment does not require prior authorization, but is subject to meeting medical necessity. Registration prior to the initial assessment is not required
- All benefits are administered on a per-member per 12-month period unless otherwise noted and are subject to medical necessity. Group (90853) and Med. Management (90862) do not require authorization.
- Check eligibility frequently on Beacon's eServices to determine number of remaining visits and on your eMEVS machine to determine client's Medicaid status

Beacon has established specific policies and procedures for both Affinity Health Plan and Neighborhood Health Plan members – **It's important to request written copies.**

Website Address – www.beaconhealthstrategies.com

*Some agencies are receiving reimbursement for the initial assessment (90801) from Beacon for Medicaid clients (be sure to confirm with Beacon). All services following the initial assessment are carved out to the State. This does not apply to Family Health Plus or Child Health Plus.

BLUE CROSS/BLUE SHIELD OF WESTERN NEW YORK – Buffalo Geographic Area

- Authorization is not required for outpatient chemical dependency.
- Co-payments vary by plan.
- Website Address – www.bcbswny.com

BLUE SHIELD OF NORTHEASTERN NEW YORK – Albany Geographic Area

Inpatient

- Pre-certification is required for inpatient detox and rehab.
- Patient must meet all acuity indicators including failure at outpatient level of care.
- Detox – reviews are required daily for continued stay.
- Rehab – reviews are required for each seven-day period.
- Pre-certification denials may be appealed through the company physician.

Outpatient

- 60 outpatient visits per calendar year.
- IOP – required authorization is through Health Integrated.
- Billing for Psych visits are on a HCFA using CPT codes.
- Billing for visits other than psych are on a UB with revenue codes.

IOP – Revenue Code 0912 and HCPCs Code H0015

Suboxone – Revenue Code 0919 and HCPCs Code H0033

CIGNA

- CIGNA requires that clinic level of care services, 90801, 90806, 90853, 90846, and 90847, be provided by individually credentialed/contracted LCSWs. **This is one of the company's that is in violation of New York State law by requiring that only individually credentialed/contracted LCSWs may provide these services.**
- Request a Facility Contract citing New York State Insurance law. There are facilities that have been able to obtain a Facility Contract for all levels of care.
- IOP Criteria – 3 hours per day; a minimum of 3 days per week. Authorization is required prior to providing service.
- Day Treatment Criteria – Approximately 6 hours per day, up to 5 days per week. Authorization is required prior to providing service.
- Authorization is required for Inpatient Rehab.
- Client may self-pay – Appeal is required and a self-pay statement indicating type of treatment and financial responsibility must be signed prior to treatment.
- Level of Care Guidelines are available on their website www.cignabehavioral.com.

On left side of screen

Click on Providers

Click on More

Click on Clinical Resources

Click on Tools and Forms

Scroll down and click on Level of Care Guidelines.

IMPORTANT NOTE: CIGNA has advised that they are open on Saturdays and expect providers to call when applicable.

1199 NATIONAL BENEFIT & PENSION FUNDS

- Outpatient benefits – 1199 manages outpatient benefits. Member should call 1199 for approval (646-473-6900) for approval prior to evaluation. 1199 will mail authorization letter with monthly treatment form for completion.
- Members have two (2) cycles of outpatient referral per lifetime. Each cycle consists of 50 visits, however, it may be extremely difficult to obtain authorization for the second cycle.
- 1199 members do not have an IOP benefit. All certs will be for clinic level of care and will authorize additional covered services on a case-by-case basis.
- 1199 clients do not have a co-payment
- Inpatient benefits are managed by Intracorp/Care Allies
- Effective April 1, 2008, 1199SEIU Home Care Benefit Fund partnered with New York State and Fidelis to enroll over 70,000 Home Care Benefit Fund members (Group 199H) into the 1199SEIU Fidelis FHP Plan.
- Website Address – www.1199nbf.org

EMBLEM HEALTH

EmblemHealth is the parent company of HIP and GHI.

- See HIP for information regarding EmblemHealth CompreHealth HMO and EPO products in the CompreHealth's New York Metro Network covering the Bronx, Brooklyn, Manhattan, Queens, Staten Island, Nassau, Suffolk, and Westchester.
- See ValueOptions GHI-BMP for information regarding EmblemHealth GHI products. ValueOptions is managing the GHI EmblemHealth lines of business as part of the GHI-BMP National Network and are listed below.

EmblemHealth PPO and EPO lines of business managed by ValueOptions:

1. PPO
 2. InBalance PPO
 3. ConsumerDirect PPO
 4. EPO
 5. InBalance EPO
 6. ConsumerDirect EPO
- Additional information is available on the EmblemHealth website; www.emblemhealth.com - select "Plan Options"

IMPORTANT NOTE RE GHI: If a client has Medicare coverage, GHI will not cover services rendered in a facility that does not participate with Medicare.

EMPIRE BLUE CROSS/BLUE SHIELD

- 12 Pass Through Visits – Effective January 2008, Empire instituted a policy of 12 Pass Through Visits for routine outpatient services that does not require pre-certification per provider per calendar year. A routine outpatient visit is defined as an individual, group, or family therapy visit, typically lasting under one (1) hour.
- Authorization is required prior to the 13th outpatient visit per provider each calendar year and participating providers will need to complete an Outpatient Treatment Report (OTR) form and submit to Empire before the 13th visit.
- 90801 does not require pre-certification but is considered inclusive if admit is to an outpatient higher level of care e.g., IOP or Day Treatment/Partial Hospitalization.
- IOP Criteria – 3 hours per day; a minimum of 3 times per week.
- The member's benefit maximums for annual outpatient still apply. It is very important to confirm eligibility and benefit availability prior to providing services.
- The above policy does not apply to outpatient visits for alcohol or substance abuse treatment provided by non-participating providers, Intensive Outpatient Program (IOP) or Partial Hospitalization Program (PHP/Day Treatment).
- Inpatient Rehab requires pre-authorization.
- Client may self-pay – a signed Statement of Financial Responsibility is required.
- The member's benefit maximums for annual outpatient still apply. It is very important to confirm eligibility and benefit availability prior to providing services.
- The 2009 Behavioral Health Medical Necessity Criteria is available on their website; www.empireblue.com.

Click on Providers & Facilities

Click on Information on Empire's Behavioral Health

Click on 2009 Behavioral Health Medical Necessity Criteria Effective January 1, 2009.

- Information regarding the 12 Pass-Through Visits is also available on the same screen as the Behavioral Health Medical Necessity Criteria.

FIDELIS CARE

- Fidelis is a Medicaid Managed Care Company – product lines of business also include Child Health Plus and Family Health Plus
- Fidelis Medicaid members may self-refer for one substance abuse assessment in any calendar year for inpatient treatment. However, all subsequent services must be authorized by the Fidelis Behavioral Health Department.
- Outpatient alcohol/substance abuse services carved out to Medicaid if category is Managed Care Coordinator and we bill the state directly, however, we bill Fidelis for the assessment.
- **EXECPTION:** Members covered under Child Health Plus and Family Health Plus are **not** carved out to the State. Fidelis is billed for all services and must authorize all services.
- Effective April 1, 2008, 1199SEIU Fidelis FHP Plan – Effective April 1, 2008 1199SEIU Home Care Benefit Fund partnered with NYS and Fidelis Care New York to enroll over 70,000 Home Care Benefit Fund members (Group 199H) into the 1199SEIU Fidelis FHP Plan.
- Website Address – www.fideliscare.org

FIDELIS CARE – Syracuse Geographic Area

- Initial authorization for one (1) evaluation and nine (9) outpatient visits can be obtained without clinical information (e.g., can be done by a business office staff member). Call 1-888-FIDELIS.
- Second set of ten (10) outpatient visits can also be obtained without clinical information when initial authorization is exhausted or expired.

HEALTH FIRST

- Health First is a Medicaid Managed Care Company, but also has a Commercial line of business
- Outpatient substance abuse services are usually carved out to Medicaid and we bill the state directly. However, always confirm Medicaid status and if services are carved out to NYS on the eMEVS machine.
- Product lines of business include Child Health Plus and Family Health Plus
- **EXCEPTION:** FHP and CHP are usually billed to the managed care company.
- MHI is the HealthFirst product for commercial insurance.
- Website Address – www.healthfirstny.com

HIP (Emblem Health is the parent company of HIP and GHI)

- HIP has introduced 2 new products underwritten and managed by HIP: EmblemHealth CompreHealth HMO and EmblemHealth CompreHealth EPO as part of the CompreHealth NY Metro Network.
- The rates negotiated with HIP will also apply to Vytra, Connecticare, and the Perfecthealth Insurance Company, however, always check the back of the member's ID card for billing addresses and telephone numbers.
- HIP also offers the SmartStart Program in conjunction with the Long Island Hospital Network on Long Island available to small and large employer groups.
- The following services do not require prior approval: 90801, 90806, 90846, 90847, 90853, and IOP (90857). However, it is extremely important to verify the member's benefits and eligibility prior to rendering treatment.
- 90862 can be billed on same day as group – With the exception of 90862, HIP will **NOT** pay for two services on the same day including an evaluation if the admit is on the same day.
- IOP Criteria – 1-3 hours per day and 3-5 times per week. Recommendation: Schedule a client from HIP/Vytra in a 2-hour IOP session to avoid any problems. PRE-CERT IS NOT REQUIRED.
- Day Treatment Criteria: 4 hours per day – minimum of 3 days per week plus an educational group 1 hour per day, minimum of 2 days per week.
- HIP's preferred lab is Quest Diagnostics – send all outpatient laboratory tests to Quest. Quest will bill HIP directly and HIP members must never be billed for laboratory services.
- HIP members can self pay – appeal process required for inpatient; you may inquire about an appeal for IOP, however, clinic does not require an appeal.
- Website Address – www.hipusa.com
- Vytra website address – www.vytra.com
- EmblemHealth website address – www.emblemhealth.com

INDEPENDENT HEALTH – Buffalo Geographic Area

- Authorizations and referrals are required for outpatient chemical dependency for Government Programs only.
- Authorization is required for non-Government plans.
- Outpatient benefit is normally 60 visits per year.
- Co-payments vary by plan.
- Website Address – www.independenthealth.com

MAGELLAN

- Pre-cert is required for all levels of care.
- IOP Criteria – 3 hours per day; a minimum of 3 times per week.
- Day Treatment – Minimum of 4 hours per day; 3 times per week.
- IOP billing – Use Revenue Code 906 **without** a CPT-4 Code.
- Inpatient, IOP, and Day Treatment rates are negotiable, however, clinic services are reimbursed per Magellan’s rate schedules.
- Client may self-pay – a signed self-pay statement is recommended and an appeal process is required. Once the appeal process has been started, you may place the client on a self-pay plan, however, if the denial is reversed, any monies collected must be returned to the client.
- Magellan’s 2009 Medical Necessity Criteria is available on their website; www.magellanhealth.com or www.magellanprovider.com. The second website address brings you directly you to the provider screen.

Click on Clinical Guidelines under Get Information

Click on Medical Necessity Criteria

Click on Medical Necessity Criteria – 2009

MHN

- MHN requires that clinic level of care services, 90801, 90806, 90853, 90846, and 90847, be provided by individually credentialed/contracted LCSWs. **This is one of the company's that is in violation of New York State law by requiring that only individually credentialed/contracted LCSWs may provide these services.**
- IOP Criteria – 3 hours per day; a minimum of 3 times per week (can include clinic group, individual, or family as part of the 3-hour time frame)
- Day Treatment Criteria – A minimum of 20 hours per week; half-day partial is up to 20 hours per week but not to exceed 4 hours per day.
- 90801 – Pre-cert is required and MHN will NOT reimburse an assessment if admit is on the same day; the assessment is included in the first day's per diem rate. This applies to all services.
- Client may self-pay – appeal is required if denial is based on medical necessity.
- Website Address – www.mhn.com

MVP (Managed by ValueOptions as of 9/1/2009) – Syracuse Geographic Area

- Transition benefits for clients in treatment prior to 9/1/2009:
Therapy – 8 sessions or 90 days, whichever comes first.
ValueOptions Registration Form (ORF) is required for additional sessions.
- Outpatient Utilization process:
Therapy – 8 pass-through sessions per member per benefit year.
Additional sessions require pre-authorization.
- All authorization requests can be submitted on line using ProviderConnect
(www.valueoptions.com)
- Free direct claim submission on website.
- Call 888-274-9311 for all EDI issues.

OXFORD (Acquired by United HealthCare)

- IOP Criteria – 3 hours per day, number of times per week not specified. May include clinic group as part of the 3-hour requirement.
- Inpatient Rehab – Criteria is very stringent; 5 days is usually the maximum number authorized.
- Clients may self-pay – Client must sign written statement acknowledging financial responsibility prior to receiving treatment.
- Website Address – www.oxfordhealth.com

POMCO – Syracuse Geographic Area

- Self-insured plan administrator
- Pre-cert not required
- Tendency to deny claims based on “additional information not received”, when “additional information” was never requested.
- Reimbursement will be reduced when an EAP benefit is available but not utilized.

RMSCO – Syracuse Geographic Area

- Self-insured plan administrator
- Pre-cert not required
- 60 sessions per year cap
- Clinician may request a Plan of Treatment (POT) after initial evaluation

TOTAL CARE – Syracuse Geographic Area

- Total Care is a Medicaid Managed Care Company – inclusive of Family Health Plus
- Inpatient Services require initial authorization with clinical follow up for each seven-day period. No benefit limit, authorization is based on medical necessity.
- Outpatient Services – Billable through Medicaid as a carve out to the State.

Family Health Plus

- Requires PCP referral – this will give authorization.
- Detox – No benefit limit
- Inpatient – 30 days annually, combined with Mental Health
- Outpatient – 60 days annually, combined with Mental Health

Child Health Plus

- Free or low cost coverage for children who qualify up to age 19.

Website Address: www.totalcareny.com

UBH/OPTUMHEALTH

- UBH requires that clinic level of care services, 90801, 90806, 90853, 90846, and 90847, be provided by individually credentialed/contracted LCSWs. This is one of the company's that is in violation of New York State law by requiring that only individually credentialed/contracted LCSWs may provide these services.
- Request a Facility Contract only; citing NYS Insurance Law. There are facilities that have been able to obtain a Facility Contract for all levels of care.
- 90801 – Pre-cert is not required, however, 90801 is not a billable service; it's included in the Open Auth. SA Other/Assessment is the exception and requires authorization.
- SA Outpatient Other – Contracted service for the assessment rate if client is not admitted to treatment. This is a billable service.
- Clinic Level of Care – Reimbursement rates for services are per United Behavioral Health's National Fee Schedule for specific geographic areas.
- IOP Criteria – 3 hours per day, a minimum of 3 times per week.
- Day Treatment – 6 hours per day, 5 times per week.
- UBH Care Managers are available 24/7 to grant authorizations.
- UBH does not recognize OASAS guidelines for inpatient rehab for their commercial clients; however, they do recognize the guidelines for Medicaid clients.
- New York State Empire Plan – OptumHealth is managing the substance abuse benefits for the New York State Empire Plan effective January 1, 2009.
- Client may self-pay – a signed written statement indicating client was advised that treatment was not authorized, the reason why treatment was denied, type of treatment, and financial responsibility prior to receiving treatment.
- Preferred Lab: LabCorp
- Website Address – www.ubhonline.com. This website is for providers, not facilities, however, you will be able to print a copy of UBH's Clinical Guidelines and forms by clicking on the options on the left side of the home page. Information regarding the New York State Empire Plan is available by clicking on "Learn More" under the heading "NY State Empire Plan".

UNIVERA HEALTHCARE – Buffalo Geographic Area

- Authorization is not required for outpatient chemical dependency for Government Programs only.
- Co-payments vary by plan.
- Website Address – www.univerahealthcare.com

VALUE OPTIONS

- ValueOptions follows the criteria developed by the American Society of Addiction Medicine (ASAM) for the treatment of adults and adolescents.
- IOP Criteria – 3 hours per day, number of times per week is based on medical necessity.
- Day Treatment Criteria – a minimum of 4 hours; 3-5 times per week.
- Partial Hospitalization Criteria – 6 hours per day; 5 times per week.
- 90801 – Pre-cert is required.
- 90853 – Required length of a group session is 30-50 minutes.
- GHI-BMP National Network – ValueOptions manages the behavioral health benefits for GHI-BMP clients that include City of New York employees. You should always begin the case with the EAP if there is an EAP in place. The EAP will authorize more inpatient days or outpatient visits than the managed care company.
- The GHI-BMP National Network also includes six (6) new EmblemHealth lines of business: PPO, InBalance PPO, ConsumerDirect PPO; EPO, InBalance EPO, and ConsumerDirect EPO.
- Suffolk County Employees (EMHP) – Behavioral benefits are managed by ValueOptions.
- CHCS is ValueOptions' Medicaid and Medicare lines of business.
- GHI-BMP Contract is a 3-year contract without any increase in rates. Try to negotiate higher rates for this specific line of business.
- Clients may self-pay – Appeal process is required and per ValueOptions should be completed prior to placing a client on a self-pay plan. The appeal process may vary per benefit plan.
- ValueOptions Website – www.valueoptions.com

IMPORTANT NOTE Re GHI: If a client has Medicare coverage, GHI will not cover services rendered in a facility that does not participate with Medicare.