NOVEMBER 2013

VALUED PROVIDER eNEWSLETTER

SPOTLIGHT:

IN THIS ISSUE:

DEPRESSED ALZHEIMER'S DISEASE PATIENTS SHOW DECLINING ABILITY TO HANDLE DAILY ACTIVITIES

More symptoms of depression and lower cognitive status are independently associated with a more rapid decline in the ability to handle tasks of everyday living, according to a study by Columbia University Medical Center (CUMC) researchers in the March 2013 issue of *Journal of Alzheimer's Disease*.

"Although these findings are observational, they could suggest that providing mental health treatment for people with Alzheimer's disease might slow the loss of independence," said senior author Yaakov Stern, Ph.D., professor of neuropsychology (in neurology, psychiatry, psychology, the Taub Institute for Research on Alzheimer's Disease and the Aging Brain and the Gertrude H. Sergievsky Center) at CUMC.

"This is the first paper to show that declines in function and cognition are inter-related over time, and that the presence of depression is associated with more rapid functional decline," said Dr. Stern.

Study method

Because almost half of Alzheimer's disease patients have depression, the researchers, who were studying the long-term association between cognitive and functional abilities in the disease, also looked at the role of depressive symptoms in disease progression. They reviewed data that tracked changes in cognition, depression and daily functioning in 517 patients with probable Alzheimer's disease at New York-Presbyterian Hospital/Columbia, Johns Hopkins School of Medicine, Massachusetts General Hospital and the Hôpital de la Salpêtrière in Paris, France. Patients were assessed prospectively every six months for more than five and a half years.

"Making a prognosis for Alzheimer's disease is notoriously difficult because patients progress at such different rates," said first author Laura B. Zahodne, Ph.D., a postdoctoral fellow in the cognitive neuroscience division in the Department of Neurology and the Taub Institute at CUMC. "These results show that not only should we measure patients' memory and thinking abilities, we should also assess their depression, anxiety, and other psychological symptoms that may affect their prognosis."

Source: Columbia University Medical Center, http://www.cumc.columbia.edu/news-room/2013/03/19/depressed-alzheimers-patients-show-declining-ability-to-handle-daily-activities/

Contact Us: *Please send your comments, ideas and suggestions for upcoming editions of the Valued* Provider eNewsletter *to* PRelations@ValueOptions.com.

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Innovative Solutions. Better Health.

IMPROVING CARE COORDINATION WITH MEDICAL PROVIDERS

Coordination of care between healthcare providers is an important and necessary process for optimal patient health and wellness. This includes coordination of care between behavioral health and medical providers.

According to the National Committee for Quality Assurance (NCQA), "People who need specialists to evaluate or treat serious illnesses often do not get the best quality care because of poor coordination with the primary care providers who know them best. Specialists in many cases do not know about other conditions or preferences people have that may affect specialty care. Primary care providers in turn do not know what treatments specialists deliver or what follow-up care to deliver." [1]

Barriers to this vital communication may include:

- Time issues
- Concerns over protection of personal health information (PHI)
- Patient concerns and fears

As a mental health specialist the trust between you and your patient is a centerpiece of effective care. It is important for patients to feel they can talk openly to you about very personal matters. However, collaboration with medical providers is important to the care and treatment of your patient. How do you bridge the barrier between necessary collaboration and maintaining patient trust?

Talk openly with your patient about the importance of collaboration on issues that impact overall care and treatment. Some of the problems your patient discusses with you could have a medical basis. It is important that medical issues be explored to avoid undetected medical conditions. Obtaining a general release of information at the first appointment to ensure coordination is a good practice.

Explain in detail what will be shared and why. This will help to eliminate patient fears that "everything I say" will be shared with another provider. Explain that only information needed for your healthcare will be discussed with other providers.

Encourage questions on coordination of care. Requesting a release form to call a medical provider may raise patient concerns and questions. Encouraging questions and providing adequate time for discussion will help your patient feel more comfortable and understand you want them to receive the care they need as opposed to being "talked about".

Keep your patient in the communication loop. Help your patient understand they are "part of the team", the most important part. Providing ongoing updates on communication between you and the medical provider encourages your patient to discuss information they feel should be included and to be more open about medical issues. This information can help medical providers be aware of current symptoms, changes in health status, possible medication issues and other information that requires follow up.

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IMPROVING CARE COORDINATION WITH MEDICAL PROVIDERS, CONT'D.

Coordination of care with medical providers is an important part of caring for your patient. ValueOptions has a sample Primary Care Physician Coordination form available on our website to facilitate the exchange of patient information with primary care providers for coordination of care. The form is available under Treatment Coordination Forms in the Clinical Forms section at **http://www.valueoptions.com/providers/Clinforms.htm**.

[1]Improving Specialty Care Coordination: *NCQA's Patient-Centered Specialty Practice Recognition Program* Fact Sheet **(http://www.ncqa.org/Portals/0/Public%20Policy/2013%20PDFS/Improving%20Specialty%20Care%20Coordination.pdf)**

UPDATE ON NEW YORK CITY SERVICE CENTER'S QUALITY MANAGEMENT PROGRAM

The New York City Service Center at ValueOptions conducts many activities as part of its Quality Management Program. Designed to improve the quality of care and service received by our members, these activities include, but are not limited to:

⇒ Interventions to improve the rate of mental health ambulatory care follow-up after acute inpatient care

⇒ Interventions to increase the rate of psychiatric evaluations for members with a diagnosis of severe or moderate Major Depressive Disorder who are in outpatient treatment with a therapist other than a psychiatrist

⇒ Routine audits of randomly selected practitioner treatment records that include measurement of compliance with ValueOptions Clinical Practice Guidelines

⇒ Member and practitioner satisfaction surveys

⇒ Depression screening programs for members diagnosed with a chronic medical condition

The success of these initiatives requires our providers' knowledge, leadership and cooperation.

View more information about these and other quality management activities within the New York City region.

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VALUEOPTIONS NORTH CAROLINA SERVICE CENTER PREVENTION PROJECTS

"MedStar Family Choice and ValueOptions® are collaborating on an initiative to increase screening of pregnant women for alcohol use during pregnancy."

Alcohol Prevention During Pregnancy
MedStar Family Choice and ValueOptions® are collaborating on an initiative to increase screening of pregnant women for alcohol use during pregnancy. The incidence of alcohol use among pregnant women is unchanged since 1991 based on research published by the US Centers for Disease Control and Prevention (CDC) when comparing rates between 1991 and 2005. The National Institute on Drug Abuse in 1996 released data showing an incidence rate in 1992 of 18% for alcohol use while pregnant.

A brochure from the CDC entitled: ***Think Before You Drink*** will be enclosed in mailings to pregnant women along with other prenatal materials. The pamphlet provides education regarding the effects of alcohol on the baby and provides information should the woman need assistance to stop drinking. The pamphlet is available in English and Spanish.

ValueOptions recommends that practitioners consider using the T-ACE (T=tolerance, A= annoyed, C= cut down, E=eye opener) screening tool developed by R. J. Sokol, MD. This four item questionnaire is based on the CAGE, but was developed specifically for prenatal use. It takes about one minute to ask and provides validated screening for risk-drinking.

In addition, for high risk women, a urine test for ethylglucuronide (EtG) is now widely available. This test, if positive, indicates exposure to alcohol up to 5 days prior to the test. Verify interpretation of results with your laboratory.

Early screening can contribute to "better risk identification, secondary prevention efforts, and improved pregnancy outcomes for offspring at risk from heavy prenatal alcohol exposure". (Sokol RJ, Martier SS, Ager JW: American Journal of Obstetrics/ Gynecology 1989 Apr, 160(4): 863-8). Research by Grace Chang, MD concludes that consistent screening followed, when indicated, by brief interventions with women and their partners can result in reduced drinking levels even with high levels of use. (2005)
A copy of the T-ACE may be downloaded from the ValueOptions website
http://www.valueoptions.com/providers/Network/NCSC_State_Local_Government.htm

Please call **866-719-6032** for a copy if you do not have internet access.

Promoting Early Detection of Substance Use Disorders in Youth
Substance use disorders are a major problem in adolescents and a leading cause of mortality and injury. Although still a major health issue, adolescent substance use of all drugs and alcohol except for prescription opiates has decreased over the past five years. The use of prescription opiates continues to rise. Surprisingly some studies show over 80% of high school graduates have tried alcohol, making the use of alcohol almost normative in teens. The major clinical challenge is identifying youth who need treatment and to identify those who are at risk of developing chronic substance use disorders in adulthood. SAMHSA, through *The National Survey on Drug Use and Health* in 2006, reported that approximately 5% of youth between the ages of 12-17 need substance use treatment.

VALUEOPTIONS NORTH CAROLINA SERVICE CENTER PREVENTION PROJECTS, CONT'D.

Adolescence is marked by neurological development in areas of motivation and impulsivity which contributes greatly to substance use. Causes of use are multi-factorial and complex. Thankfully for most adolescents problematic use extinguishes in the early 20s. Programs teaching life skills and strategies to resist drug use can be helpful and early intervention is the major prevention strategy.

As a first step, it is vital to assess for problematic use in the teen population. The CRAFFT questionnaire has high reliability in 14-to-18 year olds and can be easily administered. Copies may be downloaded from the ValueOptions® website http://www.valueoptions.com/providers/Network/NCSC_State_Local_Government.htm

This version of the CRAFFT was developed by the Center for Adolescent Substance Abuse Research (CeASAR) at Children's Hospital is used with permission from CeASAR and the Massachusetts Partnership. It is designed for self-administration by the adolescent while in the waiting room. A score of two or more "yes" answers suggests a significant problem, abuse, or dependence, but is not sufficient to make a diagnosis. A clinical evaluation is indicated.

ValueOptions has a toll-free PCP Consultation Line for Pediatricians and Family Practice staffed by board certified psychiatrists call **(877) 241-5575** from 9 a.m. to 5 p.m. This service includes consultation regarding substance abuse assessment and treatment.

"Programs teaching life skills and strategies to resist drug use can be helpful and early intervention is the major prevention strategy."

HEALTHCARE REFORM… MANDATORY COMPLIANCE PROGRAM… 7 ELEMENTS… WHEEEW, WHAT'S ALL THIS *HYPE* ABOUT?

With the passage of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care Education Reconciliation Act of 2010 (the Healthcare Reform Law), Congress for the first time has required that a broad range of providers, physicians, and suppliers adopt an ethics and compliance program. Since this is now a requirement, providers will need to be more diligent in creating and maintaining their ethics and compliance programs. Failure to implement core compliance program features increases the potential risk of False Claims Act violations for failure to prevent or identify improper federal healthcare program claims and payments.

Congress has extended the requirement for mandatory ethics and compliance programs to Medicaid. States must require that providers establish a compliance program that contains the core elements established by Health and Human Services (HHS). The **Fundamental Elements of an Effective Ethics and Compliance Program** are:

1. Implementing written policies, procedures and standards of conduct;
2. Designating a compliance officer and compliance committee;
3. Conducting effective training and education;
4. Developing effective lines of communication;
5. Conducting internal monitoring and auditing;
6. Enforcing standards through well-publicized disciplinary guidelines;
7. Responding promptly to detected offenses and undertaking corrective action, and
8. ***New!*** Compliance programs must be effective by:
    - Showing compliance plans are implemented;
    - Being proactive in identifying fraud, waste & abuse;
    - Calculating how much fraud, waste & abuse have been identified, and
    - Showing how much fraud, waste & abuse have been prevented.

"States must require providers to establish a compliance program that contains the core elements established by HHS."

Providers should tailor ethics and compliance programs to their specific facility and location. It's also important to create a culture of compliance throughout the organization. **Five Practical Tips for Creating a Culture of Compliance** are:

1. Make compliance plans a priority now;
2. Know your fraud and abuse risk areas;
3. Manage your financial relationships;
4. Just because your competitor is doing something doesn't mean you can or should; call 1-800-HHS-TIPS to report suspect practices, and
5. When in doubt, ask for help.

To learn more about the ***hype***, please refer to the following:

- HHS Website
- CMS Online Manual System
- HHS-OIG Website:
- HHS-OIG's General Compliance Education Materials
- HHS-OIG's Compliance Guidance

BALANCE BILLING REMINDERS

Balance billing is the practice of billing a member or patient for the difference between the agreed upon payment rate for covered services in the provider agreement and the participating provider's usual charge for the service. An example of Balance Billing is when an in-network provider knowingly bills an eligible ValueOptions member for any coverable service beyond the applicable copayment or co-insurance.

Participating providers may not balance bill members for covered services rendered. This means that the participating provider may not bill, charge or seek reimbursement from the member for covered services, except for applicable member expenses and non-covered services. Participating providers also may not balance bill when a claim is denied for failure to obtain a required authorization for care, or for timely filing.

Balance billing **is not** when a provider bills a member if the provider determines that a member has exhausted his/her benefit or if it is determined that the eligibility information provided by ValueOptions was incorrect. It is the provider's responsibility to inform the member of the costs of services in the event the member is not eligible or has exhausted his/her benefit, to have a written policy of conditions under which the provider might seek monies directly from the member, and the costs of services, and to have the member sign such an agreement BEFORE rendering treatment.

Prior to seeking payment from a member for any services not certified (whether due to Provider's failure to secure certification where required or as determined by ValueOptions, or where applicable Payor or Payor's designee), the provider should first exhaust all appeals of any certification or authorization denial; and advise the Member that the service or services are not certified, will not be covered or paid for by ValueOptions or the Payor, and obtain written acknowledgment from the member that the Member is and will be financially responsible for all costs of such services not certified.

For more information about balance billing, please consult your provider handbook or visit us at www.ValueOptions.com to review a copy of the Provider Handbook.

"Participating providers also may not balance bill when a claim was denied for failure to obtain a required authorization for care, or for timely filing."

CHECKING MEMBER ELIGIBILITY

Checking Member Eligibility

Participating providers are contracted and credentialed to provide identified covered services to members, as defined in the provider agreement. Providers should note the coverage to members for behavioral health services, any limitations and/or exclusions and any pre-authorization and/or certification requirements for non-emergency services, as they vary by benefit plan. They also **must** verify member eligibility and benefits using on-line and/or telephonic processes made available by ValueOptions prior to rendering non-emergency services.

Detailed information about a specific member's benefit plan requirements can be obtained by calling the toll-free number on the member's identification card or by viewing a member's benefits on the 'Benefit' tab in ProviderConnect®. To search and view a member's eligibility status log into ProviderConnect and click on "Eligibility and Benefits."

PROVIDER HANDBOOK UPDATE – HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

"The updated HEDIS measures include new behavioral health measures as well as policy changes related to supplemental data."

NCQA has released the new 2014 Managed Behavioral Healthcare Organization (MBHO) standards. The new standards require MBHOs to begin reporting Healthcare Effectiveness Data and Information Set (HEDIS) measures as part of the accreditation process.

The updated HEDIS measures include new behavioral health measures as well as policy changes related to supplemental data.

The ValueOptions Provider Handbook has been updated to reflect the HEDIS changes and replaces the former Health Plan Effectiveness Data and Information Set section under Utilization Management.

VALUEOPTIONS BANK ACCOUNT CHANGE UPDATE

ValueOptions will be closing our Wells Fargo bank accounts by the end of 2013. We have opened new replacement accounts with Bank of America and BB&T bank.

No change is needed on your part, although to plan for this change, it is important that you notify your billing staff and deposit all checks you may be holding or regularly receiving from ValueOptions, which are written on our Wells Fargo accounts. If you do not deposit these checks prior to the closure of our Wells Fargo accounts, you will need to contact your customer service representative to have replacement checks issued on our new bank accounts. These actions will not be needed for those providers who have these checks electronically deposited into their accounts.

Some new accounts were opened with Bank of America and had checks issued beginning in late May. The remaining new accounts have been opened with BB&T and will have checks issued beginning in October.

To provide you as many reminders as possible, we will continue to notify you in the upcoming weeks as we receive more details regarding this change and the exact closure date of our existing Wells Fargo accounts.

NEW 2014 ELECTRONIC CLAIM SUBMISSION REQUIREMENTS

For the majority of 2013, ValueOptions has strived to communicate the importance of electronic claim submission to our provider network . With 2014 quickly approaching, ValueOptions will soon begin making electronic claim submission mandatory for new and existing providers through our recommended platform, ProviderConnect, or through other claim submission vendors.

By January 1, 2015, existing providers will be required to submit all claims electronically. For new providers with a contract date on or after April 1, 2014, electronic claim submission will be required at the time they join ValueOptions. However, small practices as defined by the Center for Medicaid Services may file an exception request.

Additional information regarding this change will be communicated to providers in the coming weeks and months, and will reference training opportunities, incentive offerings and more details regarding this new requirement.

"By January 1, 2015, existing providers will be required to submit all claims electronically."

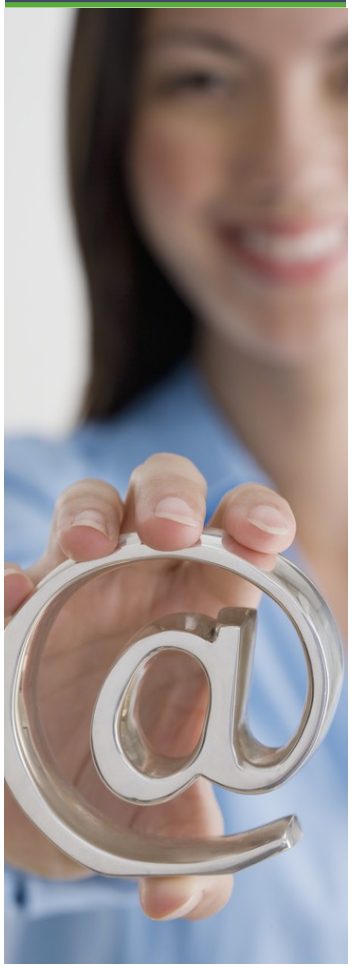
SUBMIT EAP CASE ACTIVITY AND BILLING FORMS THROUGH PROVIDERCONNECT

Network providers authorized to perform EAP Services can submit their one-page version of the Case Activity (CAF-1) form and Billing form via ProviderConnect. This enhancement reduces the time it takes to submit and be paid, as providers no longer have to fill out the paper version of the CAF by hand and will no longer have to fax the form.

Following are the steps for submitting the CAF via ProviderConnect:

- Log into ProviderConnect with your User ID and Password
    - ⇒ If you have not already registered for ProviderConnect please register by going to www.ValueOptions.com
    - ⇒ Read the User Agreement page, and if you agree, select the "yes" button
- On your ProviderConnect Home page select "Enter EAP CAF" to begin the CAF entry process. This process can also be used to submit case closing information when the participant did not show for a first or final visit and there is no billing date of service to submit.

Questions on this process can be directed to the EDI Help Desk at e-supportservices@valueoptions.com or at (888) 247-9311 from 8 am — 6 pm ET.



PROVIDERCONNECT TRAINING SCHEDULE

Title	Date	Time
An Overview of ProviderConnect	Wednesday, 11/13/13	2 pm – 3 pm ET

GIVING VALUE BACK TO THE PROVIDER WEBINAR SERIES

ValueOptions continues to offer the "Giving Value Back to the Provider" webinar series. The educational webinar series is offered to our providers twice a quarter. The presentations will introduce and discuss our new and exciting initiatives for you, the provider.

What information will the webinar include?

- Overview of ValueOptions
- Credentialing and contracting information
- Overview of clinical operations and initiatives
- ProviderConnect overview
- And much more!

⇒ **December 5th 2 pm - 4 pm ET - Click here to register.**

⇒ **December 6th 11am - 1 pm ET - Click here to register.**

ON TRACK MONTHLY WEBINARS

The ValueOptions ***On Track*** program is a client-centered outcomes informed care program designed to provide clinicians with state of the art, easy-to-use tools that promote improved client outcomes. ValueOptions clinicians may use *On Track* for all of their EAP, commercially insured or private pay clients, including, if they choose, those clients who are not ValueOptions members.

⇒ **November 13th 11 am - 12 pm ET - Click here to register.**

⇒ **December 11th 11am - 12 pm ET - Click here to register.**

"The ValueOptions On Track program is a client-centered outcomes informed care program designed to provide clinicians with state of the art, easy-to-use tools that promote improved client outcomes."