FACILITIES AND MENTAL HEALTH AGENCIES

EMBLEM BEHAVIORAL HEALTH SERVICES PROGRAM GUIDE

EmblemHealth®

Effective January 1, 2012, ValueOptions® will administer the **Emblem Behavioral Health Services Program** ("EBHSP"), which will replace GHI HMO and HIP's mental health and substance abuse services programs. ValueOptions will administer all covered inpatient, outpatient and ambulatory behavioral health services. ValueOptions will also be responsible for provider network and care management services such as credentialing, claims processing, claims payment, utilization management, case management, grievances and appeals (except for Medicare plans), and all other provider service issues related to behavioral health.

This consolidated program will serve members in plans underwritten by GHI HMO Select, Inc. ("GHI HMO"), HIP Health Plan of New York ("HIP") and HIP Insurance Company of New York ("HIPIC") (HIP and HIPIC are jointly referred to as "HIP"), as well as members managed by Vytra Health Plans Managed Systems ("VHMS").

Members of PPO plans underwritten by Group Health Incorporated ("GHI") will continue to have their behavioral health services administered by ValueOptions under their current program.

The plans served by the EBHSP include:

- **GHI HMO:** GHI HMO, GHI HMO Direct Access HMO, GHI Direct Pay HMO GHI HMO, GHI Direct Pay POS GHI POS and GHI HMO Value Plan
- **HIP:** HIPaccess® I, HIPaccess® II, HIP Classic® HMO, HIP Prime® EPO/HMO/POS/PPO, HIP Select® EPO/PPO, Direct Pay HMO/POS, HIP Medicaid, HIP Family Health Plus, HIP Child Health Plus, FEHB, Vytra HMO, EmblemHealth CompreHealth EPO/HMO and EmblemHealth Medicare HMO (which includes VIP Essential HMO, VIP HMO, VIP High Option HMO, VIP Premier Group HMO, VIP Rx Carveout HMO, Dual Eligible Group HMO SNP and Dual Eligible HMO SNP)
- **VHMS:** ASO accounts

Behavioral health benefits for members transitioning to the EBHSP will not change.

BEFORE THE PROGRAM BEGINS

Claims Adjudication Responsibility Outpatient Services

EmblemHealth and Magellan Health Services are responsible for the reimbursement of outpatient services rendered prior to the commencement of the EBHSP.

For dates of service prior to January 1, 2012, continue to submit claims for outpatient services to:

- EmblemHealth — for members in plans underwritten by HIP or managed by VHMS
- Magellan Health Services — for members in plans underwritten by GHI HMO

Claims Adjudication Responsibility Inpatient Services

EmblemHealth and Magellan Health Services are responsible for adjudicating claims for inpatient services initiated prior to the commencement of the EBHSP until the patient is discharged and/or moved to an alternate level of care. Such inpatient services include elective inpatient admissions that received prior approval and emergency admissions.

For dates of service prior to the transition, continue to submit inpatient claims to:

- EmblemHealth — for members in plans underwritten by HIP or managed by VHMS
- Magellan Health Services — for members in plans underwritten by GHI HMO

Note: Non-authorized claims submitted by out-of-network providers are subject to the patient's specific plan cost sharing (copays and/or coinsurance) and penalties. If the patient's plan does not include out-of-network benefits, then out-of-network provider claims may be denied.

Continuity of Care Transitioning To a Network Provider

Patients who are in an active course of treatment with a provider who has declined network participation in the EBHSP or has not completed the necessary application, credentialing and contracting processes with ValueOptions, may elect to continue treatment with the provider for a period up to 90 days, so long as the provider accepts the applicable current fee schedule and follows the existing policies and procedures. This will support continuity of care until the member can find a new provider who can meet their needs.

Members may find providers available to them by going to the "Find a Doctor" tool of our Web site at **www.emblemhealth.com** and entering their member ID number at the beginning of the search. Since some of our benefit plans use different networks, entering their member ID number will ensure that the search locates a provider that will participate in the member's benefit plan.

If a member chooses to remain under the care of a non-participating provider after the transitional 90-day period, services will not be covered as in-network and the member may be responsible for all or a portion of the provider's charges, depending on the EmblemHealth plan design (e.g., some plans have out-of-network benefits the member may use).

Ensuring Continuity of Care

Routine Outpatient Care: If you were delivering routine outpatient behavioral health treatment to a GHI HMO or HIP plan member prior to January 1, 2012, no approval is required for you to deliver continuing care during the 90-day transitional period.

Non-routine Outpatient Care: You can obtain prior approval to deliver continuing non-routine outpatient care after January 1, 2012 by contacting the EBHSP at **1-888-447-2526**. See the "Prior Approval Requirements" section of this guide for a listing of services that require prior approval.

Inpatient Care: If a patient is admitted to an inpatient unit for behavioral health treatment on or before the transition date, EmblemHealth (if the patient is in a plan underwritten by HIP or managed by VHMS) or Magellan Health Services (if in a plan underwritten by GHI HMO) will continue to handle their case through discharge.

Please contact the EBHSP for all discharge planning and post-admission care needs.

You can obtain prior approval to deliver continuing care after January 1, 2012 by contacting the EBHSP at **1-888-447-2526**.

Alternative Level of Care (Partial Hospitalization, Intensive Outpatient): Please contact ValueOptions with clinical information for concurrent approval if the patient is in an alternative level of care initiated and authorized by EmblemHealth or Magellan Health Services (as applicable) prior to the transition date and needs to continue that level of care after the transition date.

You can obtain prior approval to deliver continuing alternative level of care after January 1, 2012 by contacting the EBHSP at **1-888-447-2526**.

ONCE THE PROGRAM BEGINS

Secure Provider Site at **www.emblemhealth.com**

Hospitals, inpatient mental health and/or substance abuse facilities and mental health agencies will be able to view prior approvals for admissions and/or outpatient services authorized before January 1, 2012, as well as member eligibility, benefits and claims information for their patients on our secure site at **www.emblemhealth.com**.

Treating Members with a Montefiore PCP

Members who have the Montefiore logo in the lower left corner of their ID card, whether in treatment or not, will continue to access behavioral health providers in the Montefiore network. These members also may, at their option, utilize the ValueOptions network.

ValueOptions providers who provide care to a member with the Montefiore logo on their ID card must submit claims to ValueOptions. Please note that utilization management functions for behavioral health services for these members, including prior approval, will continue to be performed by Montefiore.

Plan Participation Implications

To care for all members served by the EBHSP, you are required to participate in both of the ValueOptions networks and must have both a ValueOptions facility agreement and a CHCS IPA agreement (collectively referred to as "ValueOptions Agreements").

- If you only have a CHCS IPA agreement, you will only be permitted to provide in-network care to members of HIP HMO (including commercial, HIP Medicaid, HIP Family Health Plus, HIP Child Health Plus and EmblemHealth Medicare HMO) and GHI HMO lines of business.
- If you only have a ValueOptions facility agreement you will only be permitted to provide in-network care to members of HIPIC's EPO and PPO plans and VHMS ASO accounts.

Claims Adjudication Responsibility Outpatient Services

ValueOptions will be responsible for the reimbursement of outpatient services rendered to members on or after the transition date.

For dates of service on or after the transition, submit outpatient claims to ValueOptions.

Claims Adjudication Responsibility Inpatient Services

ValueOptions will be responsible for adjudicating claims for inpatient services begun on or after the transition date.

EmblemHealth or Magellan Health Services (as applicable) will be responsible for adjudicating claims for inpatient care initiated prior to the commencement of the program until the patient is discharged and/or moved to an alternate level of care, at which point responsibility for claims adjudication, along with management of the patient's care, will transition to ValueOptions.

For dates of service on or after the transition, submit inpatient claims to ValueOptions.

Prior Approval Requirements

Prior approval is not required for routine outpatient services. ValueOptions will, however, reach out to practitioners when there are questions regarding the member's clinical treatment.

Prior approval is always required for the following services:

- Inpatient behavioral health treatment
- Ambulatory detoxification treatment
- Outpatient ECT (electro-convulsive treatment)
- Partial hospitalization
- Intensive outpatient treatment
- Neuropsychological testing
- Psychological testing

EmblemHealth®

CONTACTING VALUEOPTIONS

Submitting Claims to ValueOptions

ValueOptions encourages electronic claim submission. CMS 1500 and UB-04 electronic claim submissions are accepted according to the guidelines found on **www.ValueOptions.com**. If you are interested in electronic claim submission, please contact a ValueOptions Electronic Claims Specialist at **1-888-247-9311**.

If submitting on paper, outpatient professional services must be billed on a CMS-1500 form and include the billing and rendering providers' NPI and Tax Identification Numbers. Please note: Billed lines are limited to 10 per claim form. Please send paper claims submissions to:

ValueOptions
PO Box 803
Latham, NY 12110

To check on the status of a claim, please go to **www.ValueOptions.com** or call **1-800-235-3149**.

EmblemHealth will conduct concurrent review. Hospitals may monitor the status of the inpatient case using the Concurrent Review Status Report or the Prior Approval Inquiry feature on our Web site.

ValueOptions Online Services

ValueOptions offers online services such as ProviderConnect℠, a self-service tool that gives you access to the following features: single and multiple electronic claims submission, claims status review (for both paper and online submitted claims), eligibility status, your provider practice profile and correspondence (which includes approvals).

More Information

If you have any questions, please call the ValueOptions National Provider Services Line at **1-800-235-3149** or visit their Web site at **www.ValueOptions.com**, where you can find the ValueOptions Provider Handbook, copies of forms and billing instructions.

You can also send us any questions via e-mail using our Message Center, available from our secure provider Web site at **www.emblemhealth.com**.

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