

*We would like to take this opportunity to thank you for your dedicated service to the members of APS Healthcare Bethesda, Inc. and to share some important information with you. We hope you will find the following updates and reminders helpful. Please continue to call the Customer Service Line at 1-877-490-6854 for routine claims and credentialing questions. We look forward to working with you in 2010!*

### Changes in Practice Information

It is **extremely important** to keep APS informed of any **changes in your practice information** (billing, location, new practitioners, practitioners leaving, etc.). **Please remember that a change in Tax ID usually means a new contract!** The new contract must be in place before claims can be processed as participating under the new Tax ID. **If the new contract is not finalized, your claims will be considered out-of-network and may be denied.**

You may advise APS of changes or ask questions by contacting us by phone at **877-490-6854** or by fax at **262-787-2364**. You may also visit our Web site at [www.apshealthcare.com](http://www.apshealthcare.com) and click on "Providers" then "Provider Relations Contracts" and "Updating Information" to access the on-line update form.

### Providers Not Accepting New Patients

If you are temporarily not accepting new patients, please notify us.

Once APS is notified your status will change to "temporarily not accepting new patients" in our systems. Note, you can only remain in this status for 120 days. If you wish to extend this time or remove the status earlier, let us know.. During this time, you must still comply with requests for credentialing/recredentialing information.

There are a few ways to notify APS:

- ✓ Fax- 262-787-2364 Attn: Demographic Updates
- ✓ Email- [provideraddressupdates@apshealthcare.com](mailto:provideraddressupdates@apshealthcare.com)
- ✓ Mail- APS Healthcare, Inc.  
PO Box 991  
Brookfield, WI 53008  
Attn: Credentialing Department

### Mental Health Parity and Addiction Equity Act

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 require that mental health and substance abuse benefits have the same level of benefits as medical and surgical benefits. This means that visit limitations for mental health and substance abuse services and the copayments and coinsurance may be changing. Some requirements of the Act are:

- **Financial requirements** cannot be more restrictive for mental health and substance use disorder benefits than for medical/surgical benefits, including deductibles, copayments, coinsurance, out of pocket expenses.
- **Treatment limitations** cannot be more restrictive for mental health and substance use disorder benefits than for medical/surgical benefits, including for frequency of visits, number of visits, days of coverage, and other similar limits on the scope or duration of treatment.
- **Medical necessity determinations** along with criteria and reasons for denials of coverage for mental health and substance use disorder benefits must be made available to current or potential participants, beneficiaries or contracting providers on request. All services must still meet medical necessity criteria.
- **Out of network provider benefits** for mental health and substance use disorder benefits must be consistent with the benefits provided for medical/surgical benefits.

The impact that the Act will have on specific benefit plans, if any, will vary. Plans will be making determinations regarding the Act in the coming months.

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## Electronic Claims Filing

APS strongly encourages and accepts both Hospital and Medical HIPAA compliant **electronic claims** through WebMD, Availity, LLC (previously The Health Information Network [THIN]), and MedAvant Healthcare Solutions (previously ProxyMed). If you are already using any of these clearinghouses, there is no need to test prior to submission. The **Payer ID is 54160**.

## Claims Tip

All outpatient claims should be submitted on the CMS 1500 form. In order to expedite the processing of these claims, please be sure to include a valid ICD-9 code in box 21 and to clearly print the rendering providers name and credentials in box 31.

## NPI Identifier Numbers Reminder

The National Provider Identifier (NPI) is an administrative simplification mandate of HIPAA that requires healthcare providers to obtain and use a unique 10-digit identifier. This identifier replaces all healthcare provider numbers used in HIPAA standard transactions. The Centers for Medicare and Medicaid Services (CMS) developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. For information on this mandate or to apply for an NPI, visit <https://nppes.cms.hhs.gov>, or call 800-465-3203.

**In order for APS to process your electronic claims after the CMS deadline for compliance, the NPI number must be included.** To notify APS of your NPI, you may email [provideraddressupdates@apshealthcare.com](mailto:provideraddressupdates@apshealthcare.com), fax 262-787-2364 or mail to: APS Healthcare, Inc., PO Box 991, Brookfield, WI 53008, Attn: Credentialing Department.

## Coordination of Care and Discharge Planning

APS requires participating providers to coordinate behavioral health (BH) care with BH treatment providers, actively treating members, and physical healthcare providers, as appropriate. APS believes that such coordination of care results in the best potential treatment outcome of the member. Such coordination may be very beneficial in providing essential clinical information related to treatment planning, addressing specific member care needs, psychiatric medication management and discharge planning.

APS also believes that each member being discharged from an inpatient hospitalization should receive outpatient behavioral health care services with 7 calendar days of discharge. Such BH care may include psychotherapy, psychiatric medication management, community resources, and/or alternative care settings (partial hospitalization, intensive outpatient programming), appropriate for the individual member's needs. Participating BH providers are asked to quickly respond to requests for participation in discharge planning, related to members in inpatient care. Also BH providers are urged to provide related appointments within 7 calendar days, of the planned discharge date for the related member. Such coordination of discharge planning may prevent an emergent re-admission to a higher level of care, provide essential on-going services to continue the member's recovery/stabilization and be critical to the best potential treatment outcome.

## Outpatient Clinical Outcome Review and Evaluation

In an effort to improve clinical outcomes of outpatient treatment while lowering the administrative burden to members and providers requesting authorization, APS is implementing Outpatient Clinical Outcome Review and Evaluation (OCORE).

Beginning with authorizations requested for 2010, APS will approve up to 20 outpatient visits depending on the member's benefit plan. In order to have additional sessions approved, clinicians will need to complete and submit to APS the Outpatient Treatment Review Form (OTR). It is imperative that both pages of the OTR are completed otherwise the authorization request may be delayed. An APS staff clinician may contact the provider to discuss cases. Additional authorization will be dependent on this contact. The case may also be reviewed by an APS Medical Director.

## NEW Address for APS' Complaint and Appeals Department

Effective January 4, 2010 APS has a new address for the submission of Complaints and Appeals.

The new address is

APS Healthcare Inc.  
21 Governor's Ct  
Baltimore, MD 21244

Information submitted to the previous White Plains, NY address will be accepted March 4, 2010.