Today we are Carelon Behavioral Health. We are working on updating all documents, but some historic references to Beacon may remain.

Our name may be new, but our commitment to you remains the same.

Behavioral Health Policy and Procedure Manual for Providers /

Gold Coast Health Plan

This document contains chapters 1-7 of CHIPA/Beacon's Behavioral Health Policy and Procedure Manual for providers serving Gold Coast Health Plan Insurance members. The materials referenced within this manual are available on Beacon's website. Chapters that contain all level of care service descriptions and criteria will be posted on eServices. To obtain a copy, please call 855.765.9702.

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Chapter 1

Introduction

1.1. About this Provider Manual

This Behavioral Health Provider Policy and Procedure Manual (hereinafter, the "Manual") is a legal document incorporated by reference as part of each provider's Provider Services Agreement (PSA) with College Health IPA (CHIPA) and/or Beacon Health Strategies (Beacon).

The Manual serves as an administrative guide outlining the CHIPA and Beacon policies and procedures governing network participation, service provision, claims submission, quality management and improvement requirements, in Chapters 1-7.

- Chapter 1: Introduction
- Chapter 2: Medicare and Medicaid Requirements
- Chapter 3: Provider Network Participation
- Chapter 4: Member, Benefits, and Member Related-Policies
- Chapter 5: Quality Management and Improvement Program
- Chapter 5: Care Management and Utilization Management
- Chapter 6: Appeals
- Chapter 7: Billing Transactions

Appendix A: Level of Care Criteria is available on eServices or by calling CHIPA.

The Manual is posted on both the CHIPA website at www.chipa.com and Beacon's website at www.beaconhealthoptions.com. It is also on Beacon's eServices portal. Providers may request a printed copy of the Manual by calling Beacon at 855.765.9702, option 4 2, then option 3.

Updates to the Manual as permitted by the Provider Services Agreement (PSA) are posted on the CHIPA and Beacon websites, and notification may also be sent by postal mail and/or electronic mail. Beacon and CHIPA provide notification to network providers at least 30 days prior to the effective date of any policy or procedural change that impacts providers, such as modification in payment or covered services, unless the change is mandated sooner by state or federal requirements.

Note for CHIPA contracted providers: This provider manual sets out policies and procedures specific to Gold Coast Health Plan and its members. For all other CHIPA-contracted plans, please refer to the appropriate provider manual at www.chipa.com.

1.2. Introduction to Beacon Health Options

Beacon Health Options (Beacon), is a managed behavioral health care company. Established in 1996, Beacon's mission is to partner with Partnership HealthPlan of California members and contracted providers to improve the delivery of mental healthcare for the members we serve while helping our members live their lives to the fullest potential

Presently, the Beacon Health Options family of companies serves more than 48 million individuals on behalf of more than 350 client organizations across the country. Most often co-located at the physical location of our plan partners, Beacon's "in-sourced" approach deploys utilization managements, case managers, and provider network professionals into each local market where Beacon conducts business. Working closely with our plan partner, this approach facilitates better coordination of care for members with physical, mental, and social conditions and is designed to support a "medical home" model.

Quantifiable results prove that this approach improves the lives of individuals and their families and helps plans to better integrate mental health and physical health.

CHIPA's responsibilities include:

1. Utilization Management: 24/7 utilization review and management for all outpatient behavioral health services for all enrolled members for all covered behavioral health services based on clinical protocols developed and approved by Gold Coast Health Plan.

2. Contracting of the professional network for outpatient care

Beacon's responsibilities include:

1. Network data maintenance
2. Provider relations
3. Provider credentialing and recredentialing
4. Claims processing and claims payment (Beacon will pay claims on behalf of CHIPA.)
5. Quality management, improvement, and reporting, including HEDIS®

1.3. Beacon's Behavioral Health Services

The Gold Coast Health Plan/Beacon behavioral health program provides members with outpatient mental health benefits through the CHIPA/Beacon network of contracted providers. The primary goal of the program is to provide medically necessary care in the most clinically appropriate and cost- effective therapeutic settings. By ensuring that all plan members receive timely access to clinically appropriate behavioral health care services, the plan and Beacon believe that quality clinical services can achieve improved outcomes for our members.

1.4. Transactions and Communications with Beacon

Use any of the following means to obtain additional information from Beacon:

1. Go to the provider page of the CHIPA or Beacon website for detailed information about working with Beacon, frequently asked questions, clinical articles and practice guidelines, and links to additional resources.
2. Call the National Provider Service Line at 800.888.3944, to check member eligibility, confirm authorization, and get claims status.
3. Log on to eServices to check member eligibility and number of visits available, submit claims and authorization requests, view claims and authorization status, view/print claim reports, update practice information, and use other electronic tools for communication and transactions with Beacon.
4. Email provider.inquiry@beaconhealthoptions.com.Email providerinquiry@beaconhealthoptions.com.

Chapter 2

Provider Participation in Beacon's Behavioral Health Services Network

2.1. Network Operations

Beacon's Network Operations Department is responsible for management of the CHIPA/Beacon behavioral health provider network for the Gold Coast Health Plan contract. This role includes contracting, credentialing, provider data, and provider relations functions. Representatives are easily reached by emailing provider.inquiry@beaconhealthoptions.com, or by phone between 8:30 a.m. and 5 p.m., Pacific Time (PT), Monday through Friday, at 855.765.9702, option 2, then 3. Contract inquiries can also be made by emailing provider.inquiry@beaconhealthoptions.com.

2.2. Contracting and Maintaining Network Participation

A "participating provider" is an individual practitioner, private group practice, licensed outpatient agency, or facility that has been credentialed by CHIPA or Beacon and has signed a Provider Services Agreement (PSA) with Beacon/CHIPA. Participating providers agree to provide behavioral health services to members; to accept reimbursement directly from Beacon according to the rates set forth in the fee schedule attached to each provider's PSA; and to adhere to all other terms in the PSA, including this provider manual.

Participating providers who maintain approved credentialing status remain active network participants unless the PSA is terminated in accordance with the terms and conditions set forth therein. Beacon will always notify members when their provider has been terminated.

2.3. Electronic Transactions and Communication with Beacon

Beacon's website, www.beaconhealthoptions.com, contains answers to frequently asked questions, clinical practice guidelines, clinical articles, links to numerous clinical resources, and important news for providers. As described below, eServices and EDI are also accessed through the website.

ELECTRONIC MEDIA

To streamline providers' business interactions with Beacon, we offer three provider tools:

1. **eServices**

   eServices, Beacon's secure Web portal, supports all provider transactions, while saving providers time, postage expense, billing fees, and reducing paper waste. These services include eligibility verification, claims submissions and status, explanation of benefits (EOB), and provider information. eServices is completely free to contracted providers and is accessible 24 hours a day, seven days a week through www.beaconhealthoptions.com.

   Many fields are automatically populated to minimize errors and improve claim approval rates on first submission. Claim status is available within two hours of electronic submission. All transactions generate printable confirmation, and transaction history is stored for future reference.

   Because eServices is a secure site containing member identifying information, users must register to open an account. There is no limit to the number of users. Each provider practice will designate an account administrator. The designated account administrator controls which users can access each eServices features.

Go to our website to register for an eServices account. Have your practice/organization's NPI and tax identification number available. The first user from a provider organization or practice will be asked to sign and fax the eServices terms of use, and will be designated as the account administrator unless/until another designee is identified by the provider organization. Beacon activates the account administrator's account as soon it receives the approved terms of use.

Subsequent users are activated by the account administrator upon registration. To fully protect member confidentiality and privacy, providers must notify Beacon of a change in account administrator, and when any users leave the practice.

The account administrator should be an individual in a management role, with appropriate authority to manage other users in the practice or organization. The provider may reassign the account administrator at any time by emailing provider.inquiry@beaconhealthoptions.com.

2. Electronic Data Interchange

Electronic data interchange (EDI) is available for claims submission and eligibility verification directly by the provider to Beacon or via an intermediary. For information about testing and setup for EDI, please go to www.beaconhealthoptions.com.

Beacon accepts standard HIPAA 837 professional and institutional health care claim transactions and provides 835 remittance advice response transactions. Beacon also offers member eligibility verification through the 270 and 271 transactions.

To submit EDI claims through an intermediary, contact the intermediary, contact the intermediary for assistance. If using Office Ally, use Beacon's Office Ally payer ID is 43324; Gold Coast Health Plan's ID is 103.

TABLE 2-1: ELECTRONIC TRANSACTIONS AVAILABILITY

TRANSACTION/CAPABILITY	ESERVICES	EDI
Verify member eligibility, benefits, and co-payments	Yes	Yes (HIPAA 270/271)
Update practice information	Yes	No
Submit claims	Yes	Yes (HIPAA 837)
Upload EDI claims to Beacon and view EDI upload history	Yes	Yes (HIPAA 837)
View claim status and print EOBs	Yes	Yes (HIPAA 835)
Print claims reports and graphs	Yes	No
Download electronic remittance advice	Yes	Yes (HIPAA 835)

TRANSACTION/CAPABILITY	ESERVICES	EDI
EDI acknowledgment and submission reports	Yes	Yes (HIPAA 835)
Pend authorization requests for internal approval	Yes	No
Access CHIPA's level of care criteria and provider manual	Yes	No

EMAIL

Beacon encourages providers to communicate via email (non-PHI content only). Beacon often uses email as the quickest and most efficient method of communication to disperse information including, but not limited to, monthly bulletins, quarterly surveys, and changes to regulatory requirements. Providers may contact Beacon via email for a quick and convenient way to receive assistance and training regarding claims submission, training questions, etc. by contacting provider.inquiry@beaconhealthoptions.com. We strongly encourage providers to submit a current email address to provider operations at network@chipa.com to be added to the provider database.

COMMUNICATION OF MEMBER INFORMATION

In keeping with HIPAA requirements, providers are reminded that personal health information (PHI) should not be communicated via email, other than through Beacon's eServices. PHI may be communicated by telephone or secure fax.

It is a HIPAA violation to include any patient identifying information or PHI in non-secure email through the internet.

2.4. Appointment Access Standards

TABLE 2-2: APPOINTMENT STANDARDS AND AFTER HOURS ACCESSIBILITY

TYPE OF APPOINTMENT/SERVICE	APPOINTMENT ACCESS TIME FRAMES AND EXPECTATIONS
General Appointment Standards	
Routine/Non-Urgent Services	Within 10 business days
Urgent Care	Within 48 hours
Emergency, Non-Life-Threatening Services	Immediately; within 6 hours
Non-Urgent Follow-Up Services	Within 10 business days

TYPE OF APPOINTMENT/SERVICE	APPOINTMENT ACCESS TIME FRAMES AND EXPECTATIONS
Service Availability and Hours of Operation	
On-Call	▪ 24-hour on-call services for all members in treatment ▪ Ensure that all members in treatment are aware of how to contact the treating or covering provider after hours and during provider vacations
Crisis Intervention	▪ Services must be available 24 hours per day, 7 days per week. ▪ Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours. ▪ After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician, agency-affiliated staff, crisis team, or hospital emergency room.
Outpatient Services	▪ Outpatient providers should have services available Monday through Friday from 9 a.m. to 5 p.m., as well as evenings and weekends. In order to meet this requirement, Beacon expects contracted providers to have office hours a minimum of 20 hours per week; evening and/or weekend hours should also be available at least two days per week.
Interpreter Services	▪ Under state and federal law, providers are required to arrange for interpreter services to communicate with individuals with limited English proficiency and those who are deaf or hard-of-hearing, at no cost to the member. To arrange for a face-to-face interpreter, providers should call Beacon member services at 855.765.9702 at least three business days in advance of the appointment. Telephonic interpretation services are available 24 hours a day, 7 days a week by contacting Beacon with the member at 855.765.9702.
Cultural Competency	▪ Providers must ensure that members have access to medical interpreters, signers and TTY services to facilitate communication when necessary and ensure that clinicians and agency are sensitive to the diverse needs of plan members. Training is made available for all providers to meet California Department of Health Care Services (DHCS) cultural sensitivity requirements. Contracted providers are expected to provide services in a culturally competent manner at all times and to contact Beacon immediately if they

TYPE OF APPOINTMENT/SERVICE	APPOINTMENT ACCESS TIME FRAMES AND EXPECTATIONS
	are referred a member who presents with cultural or linguistic needs they may not be qualified to address.

Providers are required to meet these standards, and to notify Beacon if they are temporarily or permanently unable to meet the standards. If a provider fails to begin services within these access standards, notice is sent out within one business day informing the member and provider that the waiting time access standard was not met.

2.5. Beacon's Provider Database

Beacon maintains a database of provider information as reported to us by providers. The accuracy of this database is critical to Beacon and the plan's operations, for such essential functions as:

- Reporting to the plan for mandatory reporting requirements
- Periodic reporting to the health plan for updating printed provider directories
- Identifying and referring members to providers that are appropriate and to available services to meet their individual needs and preferences
- Network monitoring to ensure member access to a full continuum of services across the entire geographic service area
- Network monitoring to ensure compliance with quality and performance standards, including appointment access standards

Provider-reported hours of operation and availability to accept new members are included in Beacon's provider database, along with specialties, licensure, language capabilities, addresses and contact information. This information is visible to members on our website and is the primary information source for Beacon staff when assisting members with referrals. In addition to contractual and regulatory requirements pertaining to appointment access, up-to-date practice information is equally critical to ensuring appropriate referrals to available appointments.

2.6. Required Notification of Practice Changes and Limitations in Appointment Access

Notice to Beacon is required for any material changes in practice, any access limitations, and any temporary or permanent inability to meet the appointment access standards above. All notifications of practice changes and access limitations should be submitted 90 days before their planned effective date or as soon as the provider becomes aware of an unplanned change or limitation.

Providers are encouraged to check the database regularly to ensure that the information about their practice is up-to-date. For the following practice changes and access limitations, the provider's obligation to notify Beacon is fulfilled by updating information using the methods indicated below.

TABLE 2-3: REQUIRED NOTIFICATIONS

TYPE OF INFORMATION	METHOD OF NOTIFICATION	
	ESERVICES	EMAIL
General Practice Information		
Change in address or telephone number of any service	Yes	Yes
Addition or departure of any professional staff	Yes	Yes
Change in linguistic capability, specialty, or program	Yes	Yes
Discontinuation of any covered service listed in Exhibit A of the provider's PSA	Yes	Yes
Change in licensure or accreditation of provider or any of its professional staff	Yes	Yes
Appointment Access		
Change in licensure or accreditation of provider or any of its professional staff	Yes (license)	Yes
Change in hours of operation	Yes	Yes
Is no longer accepting new patients	Yes	Yes
Is available during limited hours or only in certain settings	Yes	Yes
Has any other restrictions on treating members	Yes	Yes
Is temporarily or permanently unable to meet Beacon standards for appointment access	Yes	Yes
Other		
Change in designated account administrator for the provider's eServices accounts	No*	Yes
Merger, change in ownership, or change of tax identification number (As specified in the PSA, Beacon is not required to accept assignment of the PSA to another entity.)	No*	Yes
Adding a site, service or program not previously included in the PSA, remember to specify: a. Location b. Capabilities of the new site, service, or program	No*	Yes

Note that eServices capabilities are expected to expand over time, so that these and other changes may become available for updating in eServices.

2.7. Adding Sites, Services, and Programs

The PSA is specific to the sites and services for which the provider originally contracted with CHIPA/Beacon.

To add a site, service or program not previously included in the PSA, the provider should notify Beacon in writing of the location and capabilities of the new site, service or program. Providers may also send an email to network@chipa.com. Beacon will determine whether the site, service or program meets an identified geographic, cultural/linguistic and/or specialty need in our network and will notify the provider of its determination.

If Beacon agrees to add the new site, service or program to its network, we will advise the provider of applicable credentialing requirements. In some cases, a site visit by Beacon will be required before approval, in accordance with Beacon's credentialing policies and procedures. When the credentialing process is complete, the site, service or program will be added to Beacon's database under the existing provider identification number, and an updated fee schedule will be mailed to the provider.

2.8. Provider Credentialing and Recredentialing

Beacon conducts a rigorous credentialing process for network providers based on Centers for Medicare & Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA) guidelines. All providers must be approved for credentialing by Beacon in order to participate in Beacon's behavioral health services network, and must comply with recredentialing standards by submitting requested information within the specified time frame. Private solo and group practice clinicians are individually credentialed, while qualified facilities are credentialed as organizations; the processes for both are described below.

Beacon actively assesses its effectiveness in addressing the needs of any minority, elderly or disabled individuals in need of services, including the capacity to communicate with members/enrollees in languages other than English. In addition, to meet the needs of other identified special populations in its service areas and any linguistic and cultural needs of the populations served, Beacon actively recruits bilingual and/or bicultural practitioners in those geographic areas where such services are indicated, including practitioners who serve deaf or hearing-impaired members/enrollees.

To request credentialing information and application(s), please email provider.inquiry@beaconhealthoptions.com.

TABLE 2-4: CREDENTIALING PROCESSES

INDIVIDUAL PRACTITIONER CREDENTIALING	ORGANIZATIONAL CREDENTIALING
Beacon individually credentials and recredentials the following categories of clinicians in private solo or group practice settings: ▪ Psychiatrists	Beacon credentials and recredentials facilities and licensed outpatient agencies as organizations. Facilities that must be credentialed by Beacon as organizations include:

▪ Physicians certified in addiction medicine ▪ Psychologists ▪ Licensed Clinical Social Workers ▪ Master's-level ANCC board certified Behavioral or Mental Health Clinical Nurse Specialists/ Psychiatric Nurses ▪ Licensed behavioral health counselors ▪ Licensed Marriage and Family therapists ▪ Licensed chemical dependency professionals ▪ Advanced chemical dependency professionals ▪ Certified alcohol counselors ▪ Certified alcohol and substance/drug abuse counselors ▪ Other behavioral healthcare specialists who are master's level or above and who are licensed, certified, or registered by the state in which they practice	▪ Licensed outpatient clinics and agencies, including hospital-based clinics ▪ Federally Qualified Healthcare Centers (FQHC)/Rural Health Clinics (RHC), accredited and non-accredited

INDIVIDUAL PRACTITIONER CREDENTIALING

To be credentialed by Beacon, practitioners must be licensed and/or certified in accordance with state licensure requirements, and the license must be in force and in good standing at the time of credentialing or recredentialing. Practitioners must submit a complete practitioner credentialing application with all required attachments. All submitted information is primary-source verified by Beacon; providers are notified of any discrepancies found and any criteria not met, and have the opportunity to submit additional, clarifying information. Discrepancies and/or unmet criteria may disqualify the practitioner for network participation.

Once the practitioner has been approved for credentialing and contracted with Beacon as a solo provider or verified as a staff member of a contracted practice, Beacon will mail a welcome packet which will include an approval letter notifying the practitioner or the practice's credentialing contact of the date on which he or she may begin to serve members of Gold Coast Health Plan.

ORGANIZATIONAL CREDENTIALING

In order to be credentialed, organizations must be licensed or certified by the state in which they operate, and the license must be in force and in good standing at the time of credentialing or recredentialing. If the organization reports accreditation by The Joint Commission (TJC), Council on Accreditation of Services for Family and Children (COA), or Council on Accreditation of Rehabilitation Facilities (CARF), such accreditation must be in force and in good standing at the time of credentialing or recredentialing of the organization. If the organization is not accredited by one of these accreditation organizations, Beacon conducts a site visit prior to rendering a credentialing decision.

The credentialed organization is responsible for credentialing and overseeing its clinical staff as Beacon does not individually credential organization-based staff. Licensed master's-level behavioral health counselors are approved to function in all contracted hospital-based, agency/clinic-based and other facility services sites.

Behavioral health program eligibility criteria include the following:

- A master's degree or above in a behavioral health field (including, but not restricted to, counseling, family therapy, psychology, etc.) from an accredited college or university
- An employee or contractor within a hospital or behavioral health clinic licensed in California that meets all applicable federal, state and local laws and regulations
- Supervision in the provision of services by a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, a licensed Psychologist, a licensed master's-level clinical Nurse Specialist, or a licensed Psychiatrist meeting the contractor's credentialing requirements
- Coverage by the hospital or behavioral health/substance use agency's professional liability coverage at a minimum of $1,000,000 each occurrence/$3,000,000 aggregate
- Absence of Medicare/Medicaid sanctions

Once the organization has been approved for credentialing and contracted with Beacon/CHIPA to serve members of one or more Gold Coast Health Plans, all licensed or certified behavioral health professionals listed may treat members in the organization setting.

RECREDENTIALING

All practitioners and organizational providers are reviewed for recredentialing within 36 months of their last credentialing approval date. They must continue to meet Beacon's established credentialing criteria and quality-of-care standards for continued participation in Beacon's behavioral health provider network. Failure to comply with recredentialing requirements, including timelines, may result in removal from the network.

2.9. Required Provider Participation

To ensure that Beacon providers are providing treatment in line with standards set forth by Medi-Cal and the health plan, Beacon requires all providers to complete a set of trainings prior to the onset of treatment of Beacon members. These trainings include, but are not limited to:

- New Provider Orientation – to be completed once, prior to seeing any Beacon members
- Cultural Competency Training – to be completed on a yearly basis

To obtain a copy of these trainings, please contact Provider Relations by email at provider.inquiry@beaconhealthoptions.com or by phone at 855.765.9702, option 4, then 5. Provider Relations also sends out an electronic quarterly survey in which all providers are expected to participate in.

Chapter 3

Members, Benefits, and Member-Related Policies

3.1. Behavioral Health Benefits

Gold Coast Health Plan offers outpatient mental health services to members with mild to moderate impairments enrolled in Medi-Cal.

Under the plan, the following services are covered, provided that services are medically necessary, delivered by contracted network providers, and that the authorization procedures in Chapter 5 are followed:

CPT CODE	DESCRIPTION
90791	Diagnostic evaluation with no medical
90792	Diagnostic evaluation with medical
99205	New patient, evaluation and management (60 min)
99212	Medication management – 10 min
99213	Medication management – 15 min
99214	Medication management – 25 min
99215	Medication management – 45 min
90832	Psychotherapy 30 (16-37) min
90834	Psychotherapy 45 (38-52) min
90837	Psychotherapy 60 (53+) min
90853	Group therapy
96112	Developmental testing (first hour)
96113	Developmental testing (each additional 30 min)
96130	Psychological testing – Evaluation (first hour)
96131	Psychological testing – Evaluation (each additional hour)
96132	Neuropsychological testing – Evaluation (first hour)
96133	Neuropsychological testing – Evaluation (each additional hour)
96116	Psychological testing (first 30 min)
96116	Neurobehavioral status exam (first hour)
96121	Neurobehavioral status exam (additional hour)

3.2. Outpatient Benefits

ACCESS

Outpatient behavioral health treatment is an essential component of a comprehensive healthcare delivery system. Plan members may access the covered outpatient mental health services by calling Beacon and registering for services. Prior to registration, Beacon will screen members for appropriate referral.

Members may also access outpatient care by referral from their primary care practitioner (PCP); however, a PCP referral is not required for behavioral health services.

INITIAL ENCOUNTERS

Members are allowed access to initial therapy sessions without prior authorization. The member/ provider needs to contact Beacon in order to complete screening to register services. Members can contact Beacon in order to complete screening to register services (determine level of care of mild/moderate). Members can also directly access in network provider and complete screening. These sessions must be provided by contracted in-network providers, and are subject to meeting medical necessity criteria. There are no benefit limitations, but members will receive an initial six-month registration after undergoing a screening by a Beacon clinician. Beacon will use claims-based algorithm to monitor utilization.

Via eServices, providers can look up the eligibility, services authorized, and number of sessions that have been billed to Beacon. To ensure coverage, the new provider is strongly encouraged to verify eligibility before beginning treatment.

GOLD COAST HEALTH PLAN BEHAVIORAL HEALTH BENEFITS

- Beneficiaries should undergo screening with a Beacon clinician prior to receiving outpatient services.
- It is a provider's responsibility to ensure the member is eligible at the time of service.
- Some specialty outpatient services, such as psychological testing, require prior authorization; see Chapter 5 for authorization procedures.
- Substance use disorder treatment is not provided through Beacon. Beneficiaries in need of substance use treatment will be given referrals for services, or the member or provider can call Ventura County Alcohol and Drug Programs at 805.981.9200.
- Benefits do not include payment for healthcare services that are not medically necessary.
- Neither the plan nor Beacon is responsible for the costs of investigational drugs or devices or the costs of non-healthcare services such as the costs of managing research or the costs of collecting data that is useful for the research project but not necessary for the enrollee's care.

3.3. Member Rights and Responsibilities

The following is the list of Beacon's Member Rights & Responsibilities.

Beacon members have the right to:

- Be treated with respect and dignity.
- Have their personal information be private based on our policies and U.S. law.
- Get information that is easy to understand and in a language they know.
- Know about the way their health benefits work.
- Know about our company, services, and provider network.
- Know about their rights and responsibilities.
- Tell us what they think your rights and responsibilities should be.
- Get care when they need it.
- Talk with you about their treatment options - regardless of cost or benefit coverage.
- Decide with you what the best plan for their care is.
- Refuse treatment if they want, as allowed by the law.
- Get care without fear of any unnecessary restraint or seclusion.
- Decide who will make medical decisions for them if they cannot make them.
- Have someone speak for them when they talk with Beacon.
- See or change their medical record, as allowed by our policy and the law.
- Understand their bill.
- Expect reasonable adjustments for disabilities as allowed by law.
- Request a second opinion.
- Tell us their complaints.
- Appeal if they disagree with a decision made by Beacon about their care.
- Be treated fairly - even if they tell us their thoughts or appeal.

Beacon members have the role to:

- Give us and you the information needed to help them get the best possible care.
- Follow the health care plan that they agreed on with you.
- Talk to you before changing their treatment plan.
- Understand their health problems as well as they can. Work with you to make a treatment plan that you all agree on.
- Read all information about their health benefits and ask for help if they have questions.
- Follow all health plan rules and policies.
- Choose an In-Network primary care physician, also called a PCP, if their health plan requires it.
- Tell their health plan or Beacon of any changes to their name, address or insurance.
- Contact you when needed, or call 911 if they have any emergency.

Beacon's Member Rights and Responsibilities Statement is available as a one -page pdf in English and Spanish for download from the website. Providers and practitioners are encouraged to ensure your practice supports the Rights and Responsibilities of our Members.

Right to Appeal Decisions Made by CHIPA

Members and their legal guardians have the right to appeal CHIPA's decision not to authorize care at the requested level of care, or CHIPA's denial of continued stay at a particular level of care according to the clinical appeals procedures described in Chapter 6. Members and their legal guardians may also request the behavioral health or substance use health care provider to appeal on their behalf according to the same procedures.

Right to Submit a Complaint or Grievance to Beacon

Members and their legal guardians have the right to file a complaint or grievance with Beacon/CHIPA regarding any of the following:

- The quality of care delivered to the member by a CHIPA contracted provider

- The CHIPA utilization review process
- The quality of service delivered by any Beacon staff member or CHIPA contracted provider
- Members and their legal guardians may call Beacon at 855.765.9702 to request assistance in filing a complaint directly with Gold Coast Health Plan

Please note, that a member must exhaust the Plan Grievance system before filing a State Fair Hearing. A State Fair Hearings must be requested within 120 days of a Plans determination.

Right to Contact Beacon Ombudsperson

Members have the right to contact Beacon's Office of Ombudsperson to obtain a copy of Beacon's Member Rights and Responsibilities statement. The Beacon Ombudsperson may be contacted at 855.765.9702 or by TTY at 800.735.2929.

PROHIBITION ON BILLING MEMBERS

Gold Coast Health Plan members may not be billed for any covered service or any balance after reimbursement by Beacon except for any applicable member share of cost.

Further, providers may not charge the plan members for any services that are not deemed medically necessary upon clinical review or which are administratively denied. It is the provider's responsibility to check benefits prior to beginning treatment of this membership and to follow the procedures set forth in this manual.

Billing Members for Covered Services is Prohibited.

The California Department of Health Care Services (DHCS) prohibits providers from charging members for Medi-Cal covered services, or having any recourse against the member or DHCS for Medi-Cal covered services rendered to the member.

The prohibition on billing of the member includes, but is not limited to, the following:

- Covered services
- Covered services provided during a period of retroactive eligibility
- Covered services once the member meets his or her share-of-cost requirement
- Co-payments, coinsurance, deductible or other cost-sharing required under a member's other health coverage
- Pending, contested, or disputed claims
- Fees for missed, broken, cancelled or same day appointments
- Fees for completing paperwork related to the delivery of care (e.g., immunization cards, WIC forms, disability forms, PM160 forms, forms related to Medi-Cal eligibility, PM160 well-child visit forms.)

MEMBER RESPONSIBILITIES

Members of Gold Coast Health Plan agree to do the following:

- Choose a PCP and site for the coordination of all medical care. Members may change PCPs at any time by contacting Gold Coast Health Plan.
- Carry their Gold Coast Health Plan identification card and show the card whenever treatment is sought.

- In an emergency, seek care at the nearest medical facility and call their PCP within 48 hours. The back of the plan identification card highlights the emergency procedures.
- Provide clinical information needed for treatment to their behavioral health care provider.
- To the extent possible, understand their behavioral health problems and participate in the process of developing mutually agreed-upon treatment goals.
- Follow the treatment plans and instructions for care as mutually developed and agreed-upon with their practitioners.

POSTING MEMBER RIGHTS OR RESPONSIBILITIES

All contracted providers must display in a highly visible and prominent place, a statement of members' rights and responsibilities. This statement must be posted and made available in languages consistent with the demographics of the population(s) served. This statement can either be Beacon's statement or a comparable statement consistent with the provider's state licensure requirements.

INFORMING MEMBERS OF THEIR RIGHTS AND RESPONSIBILITIES

Providers are responsible for informing members of their rights and respecting these rights. In addition to a posted statement of member rights, providers are also required to:

- Distribute and review a written copy of Member Rights and Responsibilities at the initiation of every new treatment episode and include in the member's medical record signed documentation of this review
- Inform members that Beacon does not restrict the ability of contracted providers to communicate openly with plan members regarding all treatment options available to them, including medication treatment, regardless of benefit coverage limitations
- Inform members that Beacon does not offer any financial incentives to its contracted provider community for limiting, denying, or not delivering medically necessary treatment to plan members
- Inform members that clinicians working at Beacon do not receive any financial incentives to limit or deny any medically necessary care

3.4. Non-Discrimination Policy and Regulations

In signing the PSA, providers agree to treat plan members without discrimination. Providers may not refuse to accept and treat a Gold Coast Health Plan member on the basis of his/her income, physical or mental condition, age, gender, sexual orientation, religion, creed, color, physical or mental disability, national origin, English proficiency, ancestry, marital status, veteran's status, occupation, claims experience, duration of coverage, race/ethnicity, pre-existing conditions, health status or ultimate payer for services. In the event that the provider does not have the capability or capacity to provide appropriate services to a member, the provider should direct the member to call Beacon for assistance in locating needed services.

Providers may not close their practice to plan members unless it is closed to all patients. The exception to this rule is that a provider may decline to treat a member for whom it does not have the capability or capacity to provide appropriate services. In that case, the provider should either contact Beacon or have the member call Beacon for assistance in locating appropriate services.

State and federal laws prohibit discrimination against any individual who is a member of federal, state, or local public assistance, including medical assistance or unemployment compensation, solely because the individual is such a member.

It is our joint goal to ensure that all members receive behavioral health care that is accessible, respectful, and maintains the dignity of the member.

3.5. Confidentiality of Member Information

All providers are expected to comply with federal, state and local laws regarding access to member information. With the enactment of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), members give consent for the release of information regarding treatment, payment and healthcare operations at the sign-up for health insurance. Treatment, payment and healthcare operations involve various activities, including, but not limited to:

- Submission and payment of claims
- Seeking authorization for extended treatment
- Quality improvement initiatives, including information regarding the diagnosis, treatment, and condition of members in order to ensure compliance with contractual obligations
- Member information reviews in the context of management audits, financial audits or program evaluations
- Chart reviews to monitor the provision of clinical services and ensure that authorization criteria are applied appropriately

MEMBER CONSENT

At every intake and admission to treatment, the provider should explain the purpose and benefits of communication to the member's PCP and other relevant providers. The behavioral health clinician should then ask the member to sign a statement authorizing the clinician to share clinical status information with the PCP and for the PCP to respond with additional member status information. The form can be found on the Provider Tools webpage, or providers may use their own form; the form must allow the member to limit the scope of information communicated. A member will need to sign a separate release for each provider he/she allows the clinician to contact.

Members can elect to authorize or refuse to authorize release of any information, except as specified in the previous section, for treatment, payment and operations. Whether consenting or declining, the member's signature is required and should be included in the medical record. If a member refuses to release information, the provider should clearly document the member's reason for refusal in the narrative section on the form.

CONFIDENTIALITY OF MEMBERS' HIV-RELATED INFORMATION

Beacon and CHIPA work in collaboration with the plan to provide comprehensive health services to members with health conditions that are serious, complex, and involve both medical and behavioral health factors. Beacon coordinates care with Gold Coast Health Plan medical and disease management programs and accepts referrals for behavioral health care management from Gold Coast Health Plan.

Information regarding HIV infection, treatment protocols and standards, qualifications of HIV/AIDS treatment specialists, and HIV/AIDS services and resources, medications, counseling and testing is

available directly from Gold Coast Health Plan. Beacon will assist behavioral health providers or members interested in obtaining any of this information by referring them to the plan's care management department. Beacon limits access to all health-related information, including HIV-related information and medical records, to staff trained in confidentiality and the proper management of patient information. Beacon's care management protocols require Beacon to provide any plan member with assessment and referral to an appropriate treatment source. It is Beacon's policy to follow federal and state information laws and guidelines concerning the confidentiality of HIV-related information.

3.6. Gold Coast Health Plan Member Eligibility

GOLD COAST HEALTH PLAN MEMBER IDENTIFICATION CARDS

Plan members are issued one card, the plan membership card. The card is not returned when a member becomes ineligible. Therefore, the presence of a card does not ensure that a person is currently enrolled or eligible with the plan.

A Gold Coast Health Plan member card contains the following information:

- Member name
- Member ID
- Effective date,
- PCP name and phone number
- Rx Plan ID and phone number

Possession of a Gold Coast Health Plan member identification card does not guarantee that the member is eligible for benefits. Providers are strongly encouraged to check member eligibility frequently.

Member eligibility changes occur frequently. To facilitate reimbursement for services, providers are strongly advised to verify a plan member's eligibility upon admission to treatment and on each subsequent date of service.

The following resources are available to assist in eligibility verification:

TABLE 3-1: MEMBER ELIGIBILITY VERIFICATION TOOLS

ONLINE	ELECTRONIC DATA INTERCHANGE (EDI)	VIA TELEPHONE
Beacon's eServices	Providers with EDI capability can use the 270/271 EDI transaction with Beacon. To set up an EDI connection, view the companion guide then contact e-support.services@beaconhealthoptions.com.	Beacon's IVR 888.210.2018

In order to maintain compliance with HIPAA and all other federal and state confidentiality/privacy requirements, providers must have their practice or organizational TIN, NPI, as well as the member's full name, plan ID and date of birth, when verifying eligibility through eServices and through Beacon's IVR.

Beacon may also assist the provider in verifying the member's enrollment in Gold Coast Health Plan when authorizing services. Due to the implementation of the Privacy Act, Beacon requires the provider to have

ready specific identifying information (provider ID#, member full name and date of birth) to avoid inadvertent disclosure of member-sensitive health information.

Please note: Member eligibility information on eServices and through IVR is updated every night. Eligibility information obtained by phone is accurate as of the day and time it is provided by Beacon. Beacon cannot anticipate, and is not responsible for, retroactive changes or disenrollments reported at a later date. Providers should check eligibility frequently.

Chapter 4

Quality Management and Improvement Program

4.1. Quality Management and Improvement Program Overview

TABLE 4-1: QM&I PROGRAM OVERVIEW

PROGRAM DESCRIPTION	PROGRAM PRINCIPLES	PROGRAM GOALS AND OBJECTIVES
Beacon administers, on behalf of Gold Coast Health Plan, a Quality Management and Improvement (QM&I) program whose goal is to continually monitor and improve the quality and effectiveness of behavioral health services delivered to members. Beacon's QM&I Program integrates the principles of continuous quality improvement (CQI) throughout our organization and the provider network.	▪ Continually evaluate the effectiveness of services delivered to Gold Coast Health Plan members ▪ Identify areas for targeted improvements ▪ Develop QI action plans to address improvement needs ▪ Continually monitor the effectiveness of changes implemented, over time	▪ Improve the healthcare status of members ▪ Enhance continuity and coordination among behavioral healthcare providers and between behavioral healthcare and physical healthcare providers ▪ Establish effective and cost-efficient disease management programs, including preventive and screening programs, to decrease incidence and prevalence of behavioral health disorders ▪ Ensure members receive timely and satisfactory service from Beacon and network providers ▪ Maintain positive and collaborative working relationships with network practitioners and ensure provider satisfaction with Beacon services ▪ Responsibly contain healthcare costs

4.2. Provider Role

Beacon employs a collaborative model of continuous QM&I, in which provider and member participation is actively sought and encouraged. In signing the PSA, all providers agree to cooperate with Beacon and the plan QI initiatives. Beacon also requires each provider to have its own internal QM&I Program to continually assess quality of care, access to care and compliance with medical necessity criteria.

To participate in CHIPA's Provider Advisory Council, email provider.inquiry@beaconhealthoptions.com. Members who wish to participate in the Member Advisory Council, should contact the Member Services Department.

4.3. Quality Performance Indicator Development and Monitoring Activities

A major component of the quality management process is the identification and monitoring of meaningful companywide Key Performance Indicators (KPI) that are established, collected, and reported for a small but critical number of performance measures across Regions or Engagement Centers and all functional areas of the company. These core performance indicators are selected by functional area leads along with associated goals or benchmarks and are approved by senior management. KPIs are reported to the Executive Leadership Team (ELT), Corporate Quality Committee (CQC), and/or Corporate Medical Management Committee (CMMC) at least annually.

All functional areas are responsible for prioritizing their resources to meet or exceed performance goals or benchmarks established for each indicator. When performance is identified below established goals and/or trends, a corrective action plan is established to improve performance.

Beacon Regions or Engagement Centers are expected to identify, track, and trend local core performance indicators relevant to the populations they serve. Client performance reporting requirements may also be required. In any case, behavioral health care access and service performance is monitored regularly, including, but not limited to:

- Access and availability to behavioral health services
- Telephone service factors
- Utilization decision timeliness, adherence to medical necessity, and regulatory requirements
- Member and provider complaints and grievances
- Member and provider satisfaction with program services
- Nationally recognized or locally prescribed care outcome indicators such as HEDIS measures whenever possible
- Potential member safety concerns, which are addressed in the Member Safety Program section of this handbook, include
    - Serious reportable events (SREs) as defined by the National Quality Forum (NQF) and Beacon, and
    - Trending Events (TEs)

Service Availability and Access to Care

Beacon uses a variety of mechanisms to measure member's access to care with participating practitioners. Unless other appointment availability standards are required by a specific client or government-sponsored health benefit program, service availability is assessed based on the following standards for participating practitioners:

- An individual with life-threatening emergency needs is seen immediately
- An individual with non-life-threatening emergency needs is seen within six (6) hours
- An individual with urgent needs is seen within 48 hours
- Routine office visits are available within 10 business days

- Routine follow-up office visits for non-prescribers are available within 30 business days of initial visit
- Routine follow-up office visits for prescribers are available within 90 business days of initial visit

The following methods may be used to monitor participating provider behavioral health service availability and member access to care:

- Analysis of member complaints and grievances related to availability and access to care
- Member satisfaction surveys specific to their experience in accessing care and routine appointment availability
- Open shopper staff surveys for appointment availability—an approach to measuring timeliness of appointment access in which a surveyor contacts participating provider's offices to inquire about appointment availability and identifies from the outset of the call that he or she is calling on behalf of Beacon
- Referral line calls are monitored for timeliness of referral appointments given to members
- Analysis and trending of information on appointment availability obtained during site visits
- Analysis of call statistics (e.g., average speed of answer, abandonment rate over five seconds)
- Annual Geo-Access and network density analysis (see Network policies and procedures)

In addition to these monitoring activities, participating providers are required by contract to report to network management when they are at capacity. This assists customer service in selecting appropriate, available participating practitioners for member referral.

Healthcare Effectiveness Data and Information Set (HEDIS®)

There are a number of ways to monitor the treatment of individuals with mental health and/or substance use conditions receive. Many of you who provide treatment to these individuals measure your performance based on quality indicators such as those to meet CMS reporting program requirements; specific state or insurance commission requirements; managed care contracts; and/or internal metrics. In most cases there are specific benchmarks that demonstrate the quality that you strive to meet or exceed.

Beacon utilizes a number of tools to monitor population-based performance in quality across regions, states, lines of business and diagnostic categories. One such tool is the Healthcare Effectiveness Data and Information Set (HEDIS) behavioral health best practice measures as published by the National Committee for Quality Assurance (NCQA) as one of our tools. Like the quality measures utilized by CMS, Joint Commission, and other external stakeholders, these measures have specific, standardized rules for calculation and reporting. The HEDIS measures allow consumers, purchasers of health care and other stakeholders to compare performance across different health plans.

While the HEDIS measures are population-based measures of our partner health plan performance and major contributors to health plan accreditation status, our partner health plans rely on us to ensure behavioral health measure performance reflects best practice. Our providers are the key to guiding their patient to keep an appointment after leaving an inpatient psychiatric facility; taking their antidepressant medication or antipsychotic medication as ordered; ensuring a child has follow up visits after being prescribed an ADHD medication; and ensuring an individual with schizophrenia or bipolar disorder has annual screening for diabetes and coronary heart disease.

There are six domains of care and service within the HEDIS library of measures:

1. Effectiveness of Care

2. Access and Availability

3. Utilization and Relative Resource Use

4. Measures Collected Using Electronic Clinical Data Systems (ECDS)

5. Experience of Care

6. Health Plan Descriptive Information

A brief description of these measures:

1. **Effectiveness of Care**: Measures that are known to improve how effective care is delivered. One very important measure in this domain is Follow-up after Mental Health Hospitalization (Aftercare). In effect, this means how long someone waits to get mental health care after they are discharged from an inpatient mental health hospital. To prevent readmission and help people get back into the community successfully, best practice is from seven to thirty days after discharge.

2. **Access/Availability**: Measures how quickly and frequently members receive care and service within a specific time. For example, the Initiation and Engagement of Drug and Alcohol Abuse Treatment measure relies on frequency and timeliness of treatment to measure treatment initiation and treatment engagement. Studies show that an individual who engages in the treatment process have better outcome and success in recovery and sobriety.

3. **Utilization and Relative Resource Use**: This domain includes evidence related to the management of health plan resources and identifies the percentage of members using a service. For example, Beacon measures Mental Health Utilization and Plan All Cause Readmissions.

4. **Measures Collected Using Electronic Clinical Data Systems (ECDS)**: This is the newest domain, and it requires calculation of outcomes by accessing data through the electronic submission of a member's electronic health record (EHR). An example of an ECDS measure is the Utilization of the PHQ-9. This demonstrates whether a PHQ-9 was administered to a patient with depression four months after initiation of treatment to measure response to treatment.

5. **Experience of Care**: This domain is specific to health plans.

6. **Health Plan Descriptive Information**: We supply Board Certification of physicians and psychologists to the plan; all other information is specific to the health plan.

Below is a brief description of the HEDIS measures that apply to the behavioral health field requirements associated with each:

1. Follow-up after Hospitalization for Mental Illness

Best practice for a member aged six or older to transition from acute mental health treatment to the community is an appointment with a licensed mental health practitioner (outpatient or intermediate treatment) within seven and/or 30 calendar days of discharge.

For this measure, NCQA requires organizations to substantiate by documentation from the member's health record all nonstandard supplemental data that is collected to capture missing service data not received

through claims, encounter data, laboratory result files, and pharmacy data feeds. Beacon requires proof-of-service documentation from the member's health record that indicates the service was received. All proof-of-service documents must include all the data elements required by the measure. Data elements included as part of the patient's legal medical record are:

· Member identifying information (name and DOB or member ID)

· Date of service

· DSM diagnosis code

· Procedure code/Type of service rendered

· Provider site/facility

· Name and licensure of mental health practitioner rendering the service

· Signature of rendering practitioner, attesting to the accuracy of the information

The critical pieces of this measure for providers/participating providers are:

- **Inpatient facilities** need to:
    - Use accurate diagnoses when submitting claims for inpatient treatment. If the diagnosis on admission is a mental health diagnosis but subsequent evaluation during the stay confirms that the primary diagnosis is substance use, please use the substance use diagnosis on the claim submitted at discharge.
    - Ensure that discharge planners educate patients about the importance of aftercare for successful transition back to their communities.
    - Ensure that follow-up visits are within seven calendar days of discharge. Note: It is important to notify the provider/participating providers that the appointment is post hospital discharge and that an appointment is needed in seven calendar days.
    - Ensure that the appointment was made with input from the patient. If the member has a pre-existing provider and is agreeable to going back to that provider schedule the appointment with that provider. If not, the location of the outpatient provider or PHP, IOP or other alternative level of care, must be approved by the member and be realistic and feasible for the member to keep that appointment.
- **Outpatient providers/participating providers** need to make every attempt to schedule appointments within seven calendar days for members being discharged from inpatient care. Providers/participating providers are encouraged to contact those members who are "no show" and reschedule another appointment.

2. Initiation and Engagement of Alcohol and other Drug Use Treatment

This measure aims to define best practice for initial and early treatment for substance use disorders by calculating two rates using the same population of members who receive a new diagnosis of Alcohol and Other Drug (AOD) use from any provider (ED, Dentist, PCP, etc.):

- **Initiation of AOD Use Treatment**: The percentage of adults diagnosed with AOD Use who initiate treatment through either an inpatient AOD admission or an outpatient service for AOD from a substance use provider AND an additional AOD service within 14 calendar days.
- **Engagement of AOD Treatment**: An intermediate step between initially accessing care and completing a full course of treatment. This measure is designed to assess the degree to which the members engage in treatment with two additional AOD services within 34 calendar days after

initiation phase ends. The services that count as additional AOD services include IOP, Partial Hospital, or outpatient treatment billed with CPT-4 or revenue codes associated with substance use treatment.

3. Antidepressant Medication Management (AMM)

The components of this measure describes best practice in the pharmacological treatment of newly diagnosed depression treated with an antidepressant by any provider by measuring the length of time the member remains on medication. There are two treatment phases:

- Acute Phase: The initial period of time the member must stay on medication for the majority of symptoms to elicit a response is 12 weeks
- Continuation Phase: The period of time the member must remain on medication in order to maintain the response is for at least six months.

4. Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

The components of this measure describes best practice in the pharmacological management of children 6-12 years newly diagnosed with ADHD and prescribed an ADHD medication by measuring the length of time between initial prescription and a follow up psychopharmacology visit and the continuation and maintenance phases of treatment.

- **Initiation Phase**: For children, 6-12 years of age, newly prescribed ADHD medication best practice requires a follow up visit with a prescriber within 30 days of receiving the medication.

For ongoing treatment with an ADHD medication, best practice requires:

- **Continuation and Maintenance (C&M) Phase**: At least two additional follow-up visits with a prescriber in the preceding nine months; and, the child remains on the medication for at least seven months.

5. Diabetes Screening for People with Bipolar Disorder or Schizophrenia Who Are Using Antipsychotic Medications (SSD)

For members with Schizophrenia or Bipolar diagnosis who were being treated with an antipsychotic medication, this measure monitors for potential Type 2 Diabetes with an HbA1C test.

6. Diabetes Monitoring for People with Diabetes and Schizophrenia Who are Using Antipsychotic Medications (SMD)

For members who have Type 2 Diabetes, a Schizophrenic or Bipolar diagnosis and are being treated with an antipsychotic this measure's best practice is an annual or more frequent LDL-C test and an HbA1c test (SMD).

7. Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)

For members with Schizophrenia or Bipolar diagnosis who are being treated with an antipsychotic medication this measure monitors for potential cardiac disease with a LDL-C test.

8. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)*

This measure is described as the percentage of members 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

9. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

For child and adolescent members (1-17) prescribed antipsychotic medication on an ongoing basis, best practice requires testing at least annually during the measurement year to measure glucose levels (Blood Glucose or HbA1C) and cholesterol levels to monitor for development of metabolic syndrome.

10. Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)

This measure identifies children and adolescents who are on two or more concurrent antipsychotic medications.

The best practice here is that multiple concurrent use of antipsychotic medications is not best practice nor approved by the FDA. While there are specific situations where a child or adolescent requires concurrent medications, the risk/benefit of the treatment regime must be carefully considered and monitoring in place to prevent adverse outcome.

11. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

For children and adolescents with a new prescription for an antipsychotic, best practice requires that the child receive psychosocial care as part of first line treatment.

First line treatment is associated with improved outcomes and adherence.

12. Utilization of the PHQ-9 to Monitor Depression for Adolescents and Adults (DMS)

For members diagnosed with depression treated in outpatient settings the PHQ-9 or PHQ-A (adolescent tool) must be administered by the outpatient treater at least once during a four-month treatment period.

13. Depression Remission or Response for Adolescents and Adults (DRR)

The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within five to seven months of the elevated score. Four rates are reported:

- **ECDS Coverage**. The percentage of members 12 and older with a diagnosis of major depression or dysthymia, for whom a health plan can receive any electronic clinical quality data.
- **Follow-Up PHQ-9**. The percentage of members who have a follow-up PHQ-9 score documented within the five to seven months after the initial elevated PHQ-9 score.
- **Depression Remission**. The percentage of members who achieved remission within five to seven months after the initial elevated PHQ-9 score.
- **Depression Response**. The percentage of members who showed response within five to seven months after the initial elevated PHQ-9 score.

Note: These measures are collected utilizing Electronic Clinical Data Sets (ECDS) as found in the provider's Electronic Medical Record. While NCQA/HEDIS is looking to expand the options for collecting this data, Beacon has yet to begin discussing this requirement with providers.

14. Follow-up After Emergency Department Visit for Mental Illness (FUM)

The percentage of emergency department (ED) visits for members six years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported:

- Follow-up visit to occur within seven days of ED discharge.
- If the seven-day visit goal is missed, the next goal is a visit within 30 days of ED discharge.

15. Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA)

The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) dependence, who had a follow up visit for AOD. Two rates are reported:

- Follow-up visit to occur within seven days of ED discharge.
- If the seven-day visit goal is missed, the next goal is a visit within 30 days of ED discharge.

Here is the complete list of HEDIS Behavioral Health measures:

Effectiveness of Care:

- **AMM**: Antidepressant Medication Management
- **ADD**: Follow-Up Care for Children Prescribed ADHD Medication
- **FUH:** Follow-Up After Hospitalization for Mental Illness
- **SSD**: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- **SMD**: Diabetes Monitoring for People with Diabetes and Schizophrenia
- **SMC**: Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
- **SAA**: Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- **APC**: Use of Multiple Concurrent Antipsychotics in Children and Adolescents
- **APM**: Metabolic Monitoring for Children and Adolescents on Antipsychotics
- **FUM**: Follow-up After Emergency Department Visit for Mental Illness
- **FUA**: Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence

Other Domains:

Access and Availability

- **IET**: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- **APP**: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Utilization/Relative Resource Use - Utilization

- **PCR**: Plan All-Cause Readmissions
- **IAD**: Identification of Alcohol and Other Drug Services
- **MPT**: Mental Health Utilization

Health Plan Descriptive Information

- **BCR**: Board Certification

Electronic Clinical Data Systems

- **DMS**: Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults
- **DRR**: Depression Remission or Response for Adolescents and Adults

Continuity and Coordination of Care

Beacon monitors continuity and coordination of care throughout its continuum of behavioral health services. Monitoring may include reviews and audits of treatment records, coordination of discharge planning between inpatient and outpatient providers/participating providers, and monitoring provider/participating provider performance on pre-determined coordination of care indicators. Processes are established seeking to avoid disruption of care for the member when there is a change in their treating provider/participating provider. Such changes may include, but are not limited to:

- A member requires a change in level of care, necessitating a new participating provider
- There are multiple providers/participating providers involved in treatment simultaneously (psychiatrist for medication management, therapist for on-going treatment)
- A change in health plans or benefit plans
- Termination of a participating provider
- A member is being treated for several (co-morbid) conditions simultaneously with multiple providers/participating providers (both behavioral health specialists, primary care, medical specialists, or providers specializing in developmental disabilities)

Screening Programs

Beacon supports the early detection and treatment of depressive and comorbid disorders to promote optimal health for members 13 years and older.

A few helpful reminders:

- Beacon offers many screening tools and programs available at no cost:
  - PCP/ Provider Toolkit
  - Depression Screening Program (PDF)
  - Comorbid Mental Health and Substance Use Disorder Screening Program (PDF)
- Use screening tools at the first visit and repeat at regular intervals as clinically indicated to identify potential symptoms that may need further evaluation.
- Depression
  - Patient Health Questionnaire 9 (PHQ-9) is a brief, multi-purpose tool for assessing depression, and is available in English, Spanish, and a variety of other languages in Beacon's PCP/ Provider Toolkit.
  - When assessing for depression, remember to rule out bipolar disorders; you may choose to use the Mood Disorder Questionnaire (MDQ).
- Suicide
  - Beacon endorses the National Action Alliance for Suicide Prevention's Recommended Standard Care for People with Suicide Risk, which screens individuals for suicide and includes a list of screening tools in the Appendix.
- Comorbid issues
  - Remember to screen for possible mental health disorders when a diagnosis of a substance use disorder is present and conversely to screen for a potential substance use disorder when a mental health disorder is present.

The CRAFFT Screening Interview (PDF) assesses for substance use risk specific to adolescents.

Learn more about Beacon's Depression Screening Program and Comorbid Screening Program at the Beacon website: https://www.beaconhealthoptions.com/material/depression-management-page/.

4.4. Treatment Records

TREATMENT RECORD REVIEWS

Participating providers are required to cooperate with treatment record reviews and audits conducted by Beacon and associated requests for copies of member records. For the purpose of conducting retrospective case reviews, treatment records for Beacon members should be maintained for the time period(s) required by applicable state and/or federal laws and/or regulations, and as detailed in the provider agreement.

Beacon may conduct treatment record reviews and/or audits:

- On an unplanned basis as part of continuous quality improvement and/or monitoring activities
- As part of routine quality and/or billing audits
- As may be required by clients of beacon
- In the course of performance under a given client contract
- As may be required by a given government or regulatory agency
- As part of periodic reviews conducted pursuant to accreditation requirements to which Beacon is or may be subject
- In response to an identified or alleged specific quality of care, professional competency or professional conduct issue or concern
- As may be required by state and/or federal laws, rules, and/or regulations
- In the course of claims reviews and/or audits
- As may be necessary to verify compliance with the provider agreement
- Beacon treatment record standards and guidelines for member treatment record reviews conducted as part of quality management activities are set out in the quality management section of this handbook.

Treatment record reviews and/or audits may be conducted through on-site reviews in the participating provider's office or facility location, and/or through review of electronic or hard copy of documents and records supplied by the participating provider. Unless otherwise specifically provided for in the provider agreement and/or other sections of this handbook with respect to a particular type of record review or audit, participating providers must supply copies of requested records to Beacon within five business days of the request.

Beacon will use and maintain treatment records supplied by participating providers for review and/or audit in a confidential manner and in accordance with applicable laws and regulations regarding the privacy or confidentiality of protected health information and/or patient identifying information. Never send original records as they will not be returned at the completion of the review or audit. Only send those sections of the record that are requested. Unless otherwise specifically provided in the provider agreement, access to and any copies of member treatment records requested by Beacon or designees of Beacon shall be at no cost. Records are reviewed by licensed clinicians. Treatment records reviews and/or audits conducted as part of Quality Management activities include application of an objective instrument(s). The instrument(s) are reviewed at least annually; Beacon reserves the right to alter/update, discontinue and/or replace such instruments in its discretion and without notice.

Following completion of treatment record reviews and/or audits, Beacon will give the participating provider a written report that details the findings. If necessary, the findings report will include a corrective action plan with specific recommendations that will enable the participating provider to more fully comply with Beacon standards for treatment records.

Participating providers will grant access for members to the member's treatment records upon written request and with appropriate identification. Participating providers should review member treatment records prior to granting access to members to ensure that confidential information about other family members and/or significant others that may be referenced and/or included therein is redacted.

TREATMENT RECORD STANDARDS

Member treatment records should be maintained in compliance with all applicable medical standards, privacy laws, state and federal rules and regulations, as well as Beacon's policies and procedures and in a manner that is current, comprehensive, detailed, organized and legible to promote effective patient care and quality review. Providers are encouraged to use only secure electronic medical record technology when available. Beacon's policies and procedures incorporate standards of accrediting organizations to which Beacon is or may be subject (e.g., NCQA and URAC), as well as the requirements of applicable state and federal laws, rules, and regulations.

References to 'treatment records' mean the method of documentation, whether written or electronic, of care and treatment of the member, including, without limitation, medical records, charts, medication records, physician/practitioner notes, test and procedure reports and results, the treatment plan, and any other documentation of care and/or treatment of the member.

Progress notes should include what psychotherapy techniques were used, and how they benefited the member in reaching his/her treatment goals. Progress notes do not have to include intimate details of the member's problems but should contain sufficient documentation of the services, care, and treatment to support medical necessity of same. Intimate details documenting or analyzing the content of conversations during a private counseling session or a group, joint, or family counseling session should be maintained within the psychotherapy notes and kept separate from the member's treatment record made available for review and audit.

Member treatment record reviews and audits are based on the record keeping standards set out below:

- Each page (electronic or paper) contains the member's name or identification number.
- Each record includes the member's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant.
- All entries in the treatment record are dated and include the responsible clinician's name, professional degree, and relevant identification number (if applicable), and modality of treatment (office-based or telehealth (if telehealth video, phone or other modality). The length of the visit/session is recorded, including visit/session start and stop times.
- Reviews may include comparing specific entries to billing claims as part of the record review.
- The record, when paper based is legible to someone other than the writer.
- Medication allergies, adverse reactions and relevant medical conditions are clearly documented and dated. If the member has no known allergies, history of adverse reactions or relevant medical conditions, this is prominently noted.
- Presenting problems, along with relevant psychological and social conditions affecting the member's medical and psychiatric status and the results of a mental status exam, are documented.
- Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented, and revised in compliance with written protocols.
- Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.
- A medical and psychiatric history is documented, including previous treatment dates, practitioner identification, therapeutic interventions and responses, sources of clinical data, and relevant family information.
- For children and adolescents, past medical and psychiatric history includes prenatal and perinatal events (when available), along with a developmental history (physical, psychological, social, intellectual and academic).
- For members 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over-the-counter drugs.

- A DSM (or the most current version of the DSM) diagnosis is documented, consistent with the presenting problems, history, mental status examination, and/or other assessment data.
- Treatment plans are consistent with diagnoses, have both objective, measurable goals and estimated timeframes for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable.
- Treatment plans are updated as needed to reflect changes/progress of the member.
- Continuity and coordination of care activities between the primary clinician, consultants, ancillary providers, and health care institutions are documented as appropriate.
- Informed consent for medication and the member's understanding of the treatment plan are documented.
- Additional consents are included when applicable (e.g., alcohol and drug information releases).
- Progress notes describe the member's strengths and limitations in achieving treatment plan goals and objectives and reflect treatment interventions that are consistent with those goals and objectives.
- Documented interventions include continuity and coordination of care activities, as appropriate.
- Dates of follow-up appointments or, as applicable, discharge plans are noted.

In addition to other requests for member treatment records included in this handbook and/or the provider agreement, member treatment records are subject to targeted and/or unplanned reviews by the Beacon Quality Management Department or its designee, as well as audits required by state, local, and federal regulatory agencies and accreditation entities to which Beacon is or may be subject to.

4.5. Clinical Practice Guidelines

Beacon/CHIPA reviews and endorses clinical practice guidelines on a regular basis to support providers in making evidence-based care treatment decisions on a variety of topics. The most up-to-date, endorsed, clinical practice guidelines (CPGs) are posted on the Beacon/CHIPA website. Included are those that have been developed or updated within the past two years and represent the best clinical information we have at this time. Others clinical practice resources, while not considered current still contain information that continues to be clinically relevant. For example, some of the guidelines may recommend specific treatment interventions without adequately addressing the sufficiency of the evidence to support the recommendation. Continued use of the guidelines is warranted because resultant positive clinical contribution outweighs the fact that the summaries of the supporting research may have lacked adequate transparency related to the process of ranking the studies necessary to meet today's standards of guideline development.

CPGs are used in collaboration with providers to help guide appropriate and clinically effective care for a variety of complex psychiatric conditions. They may also may be referred to by CCMs and Peer Advisors during reviews.

The Beacon Scientific Review Committee (SRC) and CHIPA Executive Committee (EC) reviews and/or updates each guideline at least every two years. In addition, if the original source of the guideline publishes an update or makes a change, the SRC will initiate additional review of the guideline prior to the two-year review cycle. Updates/changes are then presented to Beacon's Corporate Medical Management Committee (MMC) for final approval. Each year, Beacon measures providers' adherence to at least three (3) Clinical Practice Resources. Beacon/CHIPA has chosen the following two adult-focused and one child-focused Clinical Practice Resources for 2020 national measurement, unless otherwise required by contract. Beacon/CHIPA will review a portion of its members' medical records using the tool posted on the Beacon and CHIPA websites. Questions were developed from the resources.

As Beacon/CHIPA providers, you are expected to ensure your standards of practice align with the endorsed clinical practice guidelines.

Beacon/CHIPA welcomes provider comments about the relevance and utility of the guidelines adopted by Beacon/CHIPA, any improved client outcomes noted as a result of applying the guidelines, and about providers' experience with any other guidelines. To provide feedback or to request paper copies of the practice guidelines, please email provider.inquiry@beaconhealthoptions.com.

4.6. Outcomes Measurement

Beacon/CHIPA and Gold Coast Health Plan strongly encourage and support providers in the use of outcomes measurement tools for all members. Outcomes data is used to identify potentially high-risk members who may need intensive behavioral health, medical, and/or social care management interventions.

We receive and review aggregate data by provider including demographic information and clinical and functional status without member-specific clinical information.

TABLE 4-3: COMMUNICATION BETWEEN BEHAVIORAL HEALTH PROVIDERS AND OTHER TREATERS

COMMUNICATION BETWEEN OUTPATIENT BEHAVIORAL HEALTH PROVIDERS AND PCPS, OTHER TREATERS	COMMUNICATION BETWEEN INPATIENT/ DIVERSIONARY PROVIDERS AND PCPS, OTHER OUTPATIENT TREATERS
Outpatient behavioral health providers are expected to communicate with the member's PCP and other outpatient behavioral health providers if applicable, as follows: ▪ Notice of commencement of outpatient treatment within four visits or two weeks, whichever occurs first ▪ Updates at least quarterly during the course of treatment ▪ Notice of initiation and any subsequent modification of psychotropic medications ▪ Notice of treatment termination within two weeks Behavioral health providers may use Beacon's *Authorization for Behavioral Health Provider and PCP to Share Information Form* and the *Behavioral Health-PCP Communication Form* available for initial communication and subsequent updates, posted on the website. Providers may also use their own form that includes the following information: ▪ Presenting problem/reason for admission ▪ Date of admission	With the member's informed consent, acute care facilities are expected to contact the PCP by phone and/or by fax, within 24 hours of a member's admission to treatment. Inpatient and diversionary providers must also alert the PCP 24 hours prior to a pending discharge, and must fax or mail the following member information to the PCP within three days post-discharge: ▪ Date of discharge ▪ Diagnosis ▪ Medications ▪ Discharge plan ▪ Aftercare services for each type, including: ○ Name of provider ○ Date of first appointment ○ Recommended frequency of appointments ○ Treatment plan Inpatient and diversionary providers must make every effort to provide the same notifications and information to the member's outpatient therapist, if there is one.

COMMUNICATION BETWEEN OUTPATIENT BEHAVIORAL HEALTH PROVIDERS AND PCPS, OTHER TREATERS	COMMUNICATION BETWEEN INPATIENT/ DIVERSIONARY PROVIDERS AND PCPS, OTHER OUTPATIENT TREATERS
▪ Admitting diagnosis ▪ Preliminary treatment plan ▪ Currently prescribed medications ▪ Proposed discharge plan ▪ Behavioral health provider contact name and telephone number Request for PCP response by fax or mail within three business days of the request to include the following health information: ▪ Status of immunizations ▪ Date of last visit ▪ Dates and reasons for any and all hospitalizations ▪ Ongoing medical illness ▪ Current medications ▪ Adverse medication reactions, including sensitivity and allergies ▪ History of psychopharmacological trials Outpatient providers' compliance with communication standards is monitored through requests for authorization submitted by the provider, and through chart reviews.	Acute care providers' communication requirements are addressed during continued stay and discharge reviews documented in Beacon's member record.

4.7. Transitioning Members from One Behavioral Health Provider to Another

If a member transfers from one behavioral health provider to another, the transferring provider must communicate the reason(s) for the transfer along with the information above (as specified for communication from behavioral health provider to PCP), to the receiving provider.

Routine outpatient behavioral health treatment by an out-of-network provider is not an authorized service. Members may be eligible for continuity of care for 12 months from the date of enrollment in Gold Coast Health Plan, or to ensure that services are culturally and linguistically sensitive, individualized to meet the specific needs of the member, timely per Beacon's timeliness standards, and/or geographically accessible.

4.8. Member Safety Program

Beacon has a defined procedure for the identification, reporting, investigation, resolution and monitoring of Potential Quality of Care (PQOC) concerns. PQOC concerns are those that decrease the likelihood of desired health outcomes and that are inconsistent with current professional knowledge. These types of issues may be identified from a variety of sources, including without limitation member and provider/participating provider complaints, internal reviews, clients, government agencies and others. These concerns are resolved and monitored at both the region and network-wide level. Regional teams have a designated committee, in which the local medical director participates, that oversee the investigation and resolution of these issues through to completion.

Beacon's member safety program includes the following components: prospective identification and reporting of potential Serious Reportable Events (internal and external events), trend analysis of member and provider and client complaints, annual evaluation and updating of existing member safety policies, prevention activities and the promotion of evidenced-based practice by our network credentialed providers and Beacon employed clinicians.

Prior to 6/1/2020, Beacon's Member Safety Program utilized a model of Adverse Incidents and Quality of Care Concerns. Effective 6/1/2020, Beacon's Member Safety Program utilized a model of Potential Quality of Care (PQOC) Concerns including Serious Reportable Events (SREs) and Trending Events (TEs). Beacon adopted the National Quality Forum's (NQF) Serious Reportable Event classification system as a base for its Member Safety Program. This allows the use of a standard taxonomy across a wide variety of settings and supports standard definitions across our diverse organization. For some contracts the term adverse incident, sentinel event or major incident may be used interchangeable or may have a specific definition based on state requirements.

Serious Reportable Events (SRE) include, but not limited to:

1. Surgical or Invasive Procedures (i.e., wrong site, wrong patient, wrong procedure, foreign object, and death of ASA class 1 patient)

2. Product or Device Events (i.e., contamination, device malfunction, and embolism)

3. Patient Protection Events (i.e. discharge of someone unable to make decisions, elopement, completed suicide, attempted suicide, and self-injurious behaviors)

4. Care Management Events (i.e., medication error, fall)

5. Environmental Events (i.e., electric shock, gas, burn, restraint, seclusion, restrictive interventions)

6. Potential Criminal Events (i.e., impersonation, abduction, physical assault, and sexual behavior)

7. Beacon Specific (such as disaster management, accidents, staff misconduct, standards of care, and natural death)

Trending Events (TE) include, but are not limited to the following categories/sub-categories:

- Provider inappropriate/unprofessional behavior
    - Inappropriate boundaries/relationship with member
    - Practitioner not qualified to perform services
    - Aggressive behavior
    - Displays signs of cognitive, mental health, or substance use concerns impacting the care being provided
- Clinical practice-related issues
    - Abandoned member or inadequate discharge planning

- Timeliness, accuracy, or adequacy of diagnosis, assessment, or referral
- Delay in treatment
- Effectiveness of treatment
- Failure to coordinate care or follow clinical practice guidelines
- Failure to involve family in treatment when appropriate
- Medication error or reaction
- Treatment setting not safe

- Access to care-related issues
  - Failure to provide appropriate appointment access
  - Lack of timely response to telephone calls
  - Prolonged in-office wait time or failure to keep appointment
  - Provider non-compliant with American Disabilities Act (ADA) requirements
  - Services not available or session too short
- Attitude and service-related issues
  - Failure to allow site visit
  - Failure to maintain confidentiality
  - Failure to release medical records
  - Fraud and abuse
  - Lack of caring/concern or poor communication skills
  - Poor or lack of documentation
  - Provider/staff rude or inappropriate attitude
- Other monitored events
  - Adverse reaction to treatment
  - Failure to have or follow communicable disease protocols
  - Human rights violations
  - Ingestion of an unauthorized substance in a treatment setting
  - Non-serious injuries (including falls)
  - Property damage and/or fire setting
  - Sexual behavior

Participating providers are required to report to Beacon within 24 hours all Potential Quality of Care (PQOC) concerns involving members to Cypress.Ombuds@beaconhealthoptions.com or via confidential e-fax at 877.635.4602. Beacon investigates Potential Quality of Care Concerns (PQOC) and uses the data generated to identify opportunities for improvement in the clinical care and service members receive. Beacon tracks and trends PQOC concerns and when necessary, investigates patterns or prevalence of incidents and uses the data generated to identify opportunities for quality improvement.

Based on the circumstances of each incident, or any identified trends, Beacon may undertake an investigation designed to provide for member safety. As a result, participating providers may be asked to furnish records and/or engage in corrective action to address quality of care concerns and any identified or suspected deviations from a reasonable standard of care. Participating providers may also be subject to disciplinary action through the NCC based on the findings of an investigation or any failure to cooperate with a request for information pursuant to an adverse incident investigation.

Quality Improvement Activities/Projects

One of the primary goals of Beacon's National Quality Management Program (QMP) is to continuously improve care and services. Through data collection, measurement and analysis, aspects of care and service that demonstrate opportunities for improvement are identified and prioritized for quality improvement activities. Data collected for quality improvement projects and activities are frequently related to key industry measures of quality that tend to focus on high-volume diagnoses or services and high-risk or special populations. Data collected are valid, reliable and comparable over time. Beacon takes the following steps to ensure a systematic approach to the development and implementation of quality improvement activities:

- Monitoring of clinical quality indicators
- Review and analysis of the data from indicators
- Identification of opportunities for improvement
- Prioritization of opportunities to improve processes or outcomes of behavioral health care delivery based on risk assessment, ability to impact performance, and resource availability
- Identification of the affected population within the total membership
- Identification of the measures to be used to assess performance
- Establishment of performance goals or desired level of improvement over current performance
- Collection of valid data for each measure and calculation of the baseline level of performance
- Thoughtful identification of interventions that are powerful enough to impact performance
- Analysis of results to determine where performance is acceptable and, if not, the identification of current barriers to improving performance

Experience Surveys (formerly known as Satisfaction Surveys)

When delegated, Beacon, either directly or through authorized designees, conducts some form of experience survey to identify areas for improvement as a key component of the QMP. Experience survey participation may include members, participating providers, and/or clients.

Member experience surveys measure opinions about clinical care, participating providers, and Beacon administrative services and processes. Members are asked to complete satisfaction surveys at various points in the continuum of care and/or as part of ongoing quality improvement activities. The results of these member surveys are summarized on an annual basis. Where appropriate, corrective actions are implemented in the Beacon functional department or as applicable in the Region.

Annual participating provider satisfaction surveys measure opinions regarding clinical and administrative practices. The results of participating provider surveys are aggregated and used to identify potential improvement opportunities within Beacon and possible education or training needs for participating providers. Where appropriate, corrective actions are implemented in the Beacon functional department or as applicable in the Region.

4.9. Fraud and Abuse

Beacon's policy is to thoroughly investigate suspected member misrepresentation of insurance status and/or provider misrepresentation of services provided. Fraud and abuse are defined as follows:

- ***Fraud*** *is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable federal or state law.*
- ***Abuse*** *involves provider practices that are inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary cost to the Medicaid program.*

Examples of Provider Fraud and Abuse: Altered medical records, patterns for billing, which include billing for services not provided, up-coding or bundling and unbundling or medically unnecessary care. This list is not inclusive of all examples of potential provider fraud.

Examples of Member Fraud and Abuse: Under/unreported income, household membership spouse/absent parent), out-of-state residence, third party liability, or narcotic use/sales/distribution. This list is not inclusive of all examples of potential member fraud.

Beacon continuously monitors potential fraud and abuse by providers and members, as well as member representatives. Beacon reports suspected fraud and abuse to Gold Coast Health Plan in order to initiate the appropriate investigation. The plan will then report suspected fraud or abuse in writing to the correct authorities.

4.10. Federal False Claims Act

According to federal and state law, any provider who knowingly and willfully participates in any offense as a principal, accessory or conspirator shall be subject to the same penalty as if the provider had committed the substantive offense. The Federal False Claims Act ("FCA"), which applies to Medicare, Medicaid and other programs, imposes civil liability on any person or entity that submits a false or fraudulent claim for payment to the government.

SUMMARY OF PROVISIONS

The FCA imposes civil liability on any person who knowingly:

- Presents (or causes to be presented) to the federal government a false or fraudulent claim for payment or approval
- Uses (or causes to be used) a false record or statement to get a claim paid by the federal government
- Conspires with others to get a false or fraudulent claim paid by the federal government
- Uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money or transmit property to the federal government

PENALTIES

The FCA imposes civil penalties and is not a criminal statute. Persons (including organizations and entities such as hospitals) may be fined a civil penalty of not less than $5,500 nor more than $11,000, plus triple damages, except that double damages may be ordered if the person committing the violation furnished all known information within 30 days. The amount of damages in health care terms includes the amount paid for each false claim that is filed.

QUI TAM (WHISTLEBLOWER) PROVISIONS

Any person may bring an action under this law (called a *qui tam* relator or whistleblower suit) in federal court. The case is initiated by causing a copy of the complaint and all available relevant evidence to be served on the federal government. The case will remain sealed for at least 60 days and will not be served on the defendant so the government can investigate the complaint. The government may obtain additional time for good cause. The government on its own initiative may also initiate a case under the FCA.

After the 60-day period or any extensions have expired, the government may pursue the matter in its own name, or decline to proceed. If the government declines to proceed, the person bringing the action has the right to conduct the action on their own in federal court. If the government proceeds with the case, the *qui tam* relator bringing the action will receive between 15 and 25 percent of any proceeds, depending upon the contribution of the individual to the success of the case. If the government declines to pursue the case,

the successful *qui tam* relator will be entitled to between 25 and 30 percent of the proceeds of the case, plus reasonable expenses and attorney fees and costs awarded against the defendant.

A case cannot be brought more than six years after the committing of the violation or no more than three years after material facts are known or should have been known but in no event more than 10 years after the date on which the violation was committed.

NON-RETALIATION AND ANTI-DISCRIMINATION

Anyone initiating a qui tam case may not be discriminated or retaliated against in any manner by their employer. The employee is authorized under the FCA to initiate court proceedings for any job-related losses resulting from any such discrimination or retaliation.

REDUCED PENALTIES

The FCA includes a provision that reduces the penalties for providers who promptly self-disclose a suspected FCA violation. The Office of Inspector General self-disclosure protocol allows providers to conduct their own investigations, take appropriate corrective measures, calculate damages and submit the findings that involve more serious problems than just simple errors to the agency.

If any member or provider becomes aware of any potential fraud by a member or provider, please contact us at 855.765.9702 and ask to speak to the Compliance Officer.

4.11. Complaints

Providers with complaints or concerns should contact Beacon at the number provided below and ask to speak with the manager of Provider Relations. All provider complaints are thoroughly researched by Beacon and resolutions proposed as soon as possible, but not to exceed 20 business days.

If a plan member complains or expresses concern regarding Beacon's procedures or services, plan procedures, covered benefits or services, or any aspect of the member's care received from providers, they should be directed to call Beacon's Ombudsperson at 855.765.9702 (or TTY at 800.735.2929). Member complaint forms are also available on Beacon's website for members to complete and fax or mail to Beacon. The Member Complaint Form can be downloaded from our website.

One method of identifying opportunities for improvement in processes at Beacon is to collect and analyze the content of member complaints. The Beacon complaints and grievance process has been developed to provide a structure for timely responses and to track and trend complaint and grievance data by type/category. Complaint and grievance data is compiled and reported to the local clinical quality committees at least semi-annually.

4.12. Grievances and Appeals of Grievances

Beacon reviews and provides a timely response and resolution of all grievances that are submitted by members, authorized member representative (AMR), and/or providers. Every grievance is thoroughly investigated, and receives fair consideration and timely determination.

A grievance is any expression of dissatisfaction by a member, member representative, or provider about any action or inaction by Beacon other than an adverse action. Possible subjects for grievances include, but are not limited to, quality of care or services provided; Beacon's procedures (e.g., utilization review,

claims processing); Beacon's network of behavioral health services; member billing; aspects of interpersonal relationships, such as rudeness of a provider or employee of Beacon; or failure to respect the member's rights.

Providers may register their own grievances and may also register grievances on a member's behalf. Members, or their guardian or representative on the member's behalf, may also register grievances.

If a grievance is determined to be urgent, the resolution is communicated to the member and/ or provider verbally within 24 hours, and then in writing within three calendar days of receipt of the grievance. If the grievance is determined to be non-urgent, Beacon's Ombudsperson will notify the person who filed the grievance of the disposition of their grievance in writing, within 30 calendar days of receipt.

For both urgent and non-urgent grievances, the resolution letter informs the member or member's representative to contact Beacon's Ombudsperson in the event that they are dissatisfied with Beacon's resolution.

Member and provider concerns about a denial of requested clinical service, adverse utilization management decision, or an adverse action, are not handled as grievances. See Clinical Reconsiderations and Appeals in Chapter 6.

Chapter 5

Utilization Management

5.1. Utilization Management

Utilization management (UM) is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, care management, discharge planning and retrospective review.

CHIPA has entered into a management services agreement with Beacon to provide management services in support of CHIPA's UM functions in accordance with URAC Health UM Standards, NCQA Managed Behavioral Health Organization (MBHO) standards, and state and federal regulations.

CHIPA's UM program is administered by licensed, experienced clinicians, who are specifically trained in utilization management techniques and in Beacon's standards and protocols. All CHIPA clinicians with responsibility for making UM decisions have been made aware that:

- All UM decisions are based upon CHIPA's level of care criteria (medical necessity) for psychiatric treatment and American Society of Addiction Medicine (ASAM) criteria for all substance abuse treatment)
- Financial incentives based on an individual UM clinician's number of adverse determinations or denials of payment are prohibited
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization

Please note that the information in this chapter, including definitions, procedures, and determination and notification time frames may vary for different lines of business; such differences are indicated where applicable.

MEDICAL NECESSITY

Unless otherwise defined in the *provider agreement* and/or the applicable *member* benefit plan and/or the applicable government sponsored health benefit program, CHIPA uses the following definition of *medical necessity* in making *authorization* and/or *certification* determinations:

Medically necessary services are healthcare and services that are:

A. Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (most current version of ICD or DSM,) that threatens life, causes pain or suffering, or results in illness or infirmity

B. Expected to improve an individual's condition or level of functioning

C. Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs

D. Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications

E. Reflective of a level of service that is safe, where no equally effective, more conservative, and less resource intensive treatment is available

F. Not primarily intended for the convenience of the recipient, caretaker, or provider

G. No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency

H. Not a substitute for non-treatment services addressing environmental factors

I. Reasonable and necessary to protect life, prevent illness or disability, or to ease pain through the diagnosis or treatment of disease, illness, or injury

J. Medically Necessary services include any services needed to assist members in achieving age-appropriate growth and development, and attain, maintain, or regain functional capacity

For California Medi-Cal members, the definition of medically necessary services are services:

- reasonable and necessary to protect life, prevent significant illness or significant disability
- alleviate severe pain through the diagnosis or treatment of disease, illness, or injury
- achieve age-appropriate growth and development, and
- attain, maintain, or regain functional capacity

Additionally, when determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132 (v).

Where there is an overlap between Medicare and Medi-Cal benefits (e.g., durable medical equipment services), the CHIPA will apply the definition of medical necessity that is the more generous of the applicable Medicare and California Medi-Cal standards.

LEVEL OF CARE CRITERIA (LOCC)

CHIPA's use of scientific and evidenced base criteria sets are the basis for all medical necessity determinations. LOC criteria may vary according to individual contractual obligations, state requirements and benefit coverage. Some contracts required adherence to State or Federal-specific criteria. LOC criteria varies according to contractual requirements and member benefit coverage. Appendix A of this manual presents the LOC criteria guide CHIPA uses for individual plans for each level of care. Providers can also email provider.inquiry@beaconhealthoptions.com to request a printed copy of CHIPA's LOC criteria.

CHIPA contracts with BHS to access its proprietary Level of Care criteria set. BHS' Level of Care (LOC) criteria, as adopted by CHIPA's Executive Committee, were developed from the comparison of national, scientific and evidence based criteria sets, including but not limited to those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA) and American Academy of Child and Adolescent Psychiatry (AACAP), Substance Abuse and Mental Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM.) In September of 2015, due to state regulatory mandates, CHIPA adopted American Society of Addiction Medicine's (ASAM) Substance Use Level of Care Criteria for all substance use treatment request. As of September 2019, BHS adopted Change Healthcare's InterQual® Medical Necessity criteria. In addition to BHS' proprietary LOCC, CHIPA also adopted InterQual® criteria set.

CHIPA uses its LOC criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths, and treatment history in determining the best placement for a member. LOC criteria are applied to determine appropriate care for all members. In general, members will only be certified behavioral health services if they meet the specific medical necessity criteria for a particular level of care. However, the individual's needs and characteristics of the local service delivery system are taken into consideration prior to the making of UM decisions.

UTILIZATION MANAGEMENT TERMS AND DEFINITIONS

The definitions below describe utilization review, including the types of the authorization requests and UM determinations, as used to guide CHIPA's UM reviews and decision-making. All determinations are based upon review of the information provided and available to CHIPA at the time.

Table 5-1: CHIPA UM Terms and Definitions

TERM	DEFINITION
Adverse Benefit Determination	An Adverse Benefit Determination is defined to mean any of the following actions (including determinations involving medical necessity, appropriateness, setting, covered benefits, and financial liability) taken by CHIPA: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals. 6. For a resident of a rural area with only one MCP, the denial of the beneficiary's request to obtain services outside the network. 7. The denial of a beneficiary's request to dispute financial liability
Adverse Action (Also known as Adverse Determination)	The denial of a requested service or limited authorization of a requested service. An Adverse action may be issued as a result of the following actions or inactions by the organization including but not limited to the following: 1. A determination of a provided or proposed to be provided service that is deemed not medically necessary 2. The denial or limited authorization of a requested service, including the determination that a requested service is not a Covered Service; 3. The reduction, suspension, or termination of a previous authorization for a service; 4. The failure to act within the time frames for making authorization decisions specified by CMS and state regulations; and 5. The failure to act within the time frames for making appeal decisions by Federal and State Regulations.
Non-Urgent Concurrent Review & Decision	Any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments. A non-urgent concurrent decision may authorize or modify requested treatment over a period of time or a number of days or treatments, or deny requested treatment, in a non-acute treatment setting.
Non-Urgent Pre-Service Review & Decision	Any case or service that must be approved before the member obtains care or services. A non-urgent pre-service decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment, in a non-acute treatment setting.
Post-Service Review & Decision (Retrospective Decision)	Any review for care or services that have already been received. A post-service decision would authorize, modify or deny payment for a completed course of treatment where a pre-service decision was not rendered, based on the information that would have been available at the time of a pre- service review.

TERM	DEFINITION
Urgent Care Request & Decision	Any request for care or treatment for which application of the normal time period for a non-urgent care decision: ▪ Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, when the enrollee, who is seeking emergency services, believes in their subjective point of view that an emergency condition exists In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that could not be adequately managed without the care or treatment that is requested ▪ In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that could not be adequately managed without the care or treatment that is requested
Urgent Concurrent Review Decision	Any review for a requested extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments in an acute treatment setting, when a member's condition meets the definition of urgent care, above
Urgent Pre-Service Decision	Formerly known as a pre-certification decision, any case or service that must be approved before a member obtains care or services in an inpatient setting, for a member whose condition meets the definition of urgent care above. An urgent pre-service decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment in an acute treatment setting.

AUTHORIZATION PROCEDURES AND REQUIREMENTS

This section describes the processes for obtaining registration for an outpatient level of care, and for CHIPA's medical necessity determinations and notifications. In all cases, the treating provider is responsible for following the procedures and requirements presented, in order to ensure payment for properly submitted claims.

Administrative denials may be rendered when applicable authorization procedures, including time frames, are not followed.

MEMBER ELIGIBILITY VERIFICATION

The first step in registering a member for care or seeking authorization is to determine the member's eligibility. Since member eligibility changes occur frequently, providers are advised to verify a plan member's eligibility upon admission to, or initiation of treatment, as well as on each subsequent day or date of service to facilitate reimbursement for services. Instructions for verifying member eligibility are presented in Chapter 3.

Member eligibility can change, and possession of a Gold Coast Health Plan member identification card does not guarantee that the member is eligible for benefits. *Providers are strongly encouraged to check Beacon's eServices or by calling IVR at 888.210.2018.*

5.2. Clinician Availability

Our clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention, triage and referral procedures and are available 24 hours a day, seven days a week, to take emergency calls from members, their guardians, and providers. If CHIPA does not respond to the call within 30 minutes, authorization for medically necessary treatment can be assumed, and the reference number will be communicated to the requesting facility/provider by the utilization review clinician within four hours.

TABLE 5-2: AUTHORIZATION PROCEDURES AND REQUIREMENTS

CPT CODE	DESCRIPTION	AUTHORIZATION REQUIREMENTS
90791	Diagnostic evaluation with no medical	Patient screening (no authorization requirement)
90792	Diagnostic evaluation with medical	
99205	New patient, evaluation and management (60 min)	
99212	Medication management – 10 min	Patient screening(no authorization requirement)
99213	Medication management – 15 min	
99214	Medication management – 25 min	
99215	Medication management – 45 min	
90832	Psychotherapy 30 (16-37) min	Patient screening (no authorization requirement)
90834	Psychotherapy 45 (38-52) min	
90837	Psychotherapy 60 (53+) min	
90853	Group therapy	
96112	Developmental testing (first hour)	Patient screening (no authorization requirement)
96113	Developmental testing (each additional 30 minutes)	
96130	Psychological testing – Evaluation (first hour)	
96131	Psychological testing – Evaluation (each additional hour)	Patient screening(no authorization requirement)
96132	Neuropsychological testing – Evaluation (first hour)	
96133	Neuropsychological testing – Evaluation (each additional hour)	
96136	Psychological testing (first 30 min)	

CPT CODE	DESCRIPTION	AUTHORIZATION REQUIREMENTS
96116	Neurobehavioral status exam (first hour)	
96121	Neurobehavioral status exam (additional hour)	

OUTPATIENT SERVICES

Initial Screening	The following services require that members undergo a screening and receive a six month-registration: members can also self-refer to a network provider who can complete the screening). As presented in Chapter 3, plan members are allowed routine mental health office visits without authorization after undergoing a screening and registration. Beneficiaries or providers can contact Beacon to provide clinical information to complete registration process for services.
Services Requiring Authorization	The following services require CHIPA's prior authorization: Out-of-network service is not a covered benefit if it can be provided in network. It may be authorized in some circumstances where needed care is not available within the network.
Notice of Authorization Determination	Members must be notified of all pre-service and concurrent denial decisions and all acute pre-service and concurrent denial decisions. The denial notification letter sent to the member or member's guardian, practitioner, and/or provider includes the specific reason for the denial decision, the member's presenting condition, diagnosis, and treatment interventions, the reason(s) why such information does not meet the medical necessity criteria, reference to the applicable benefit provision, guideline, protocol or criterion on which the denial decision was based, and specific alternative treatment option(s) offered by CHIPA, if any. Based on state and/or federal statutes, an explanation of the member's appeal rights and the appeals process is enclosed with all denial letters. Denials for extended outpatient services may be appealed by the member or provider and are subject to the reconsideration process outlined in Chapter 6.

5.3. Inadequate or Incomplete Clinical Review

All requests for clinical information must receive response via telephone or fax. Information must be tailored to the individual's current treatment plan and service needs. CHIPA reserves the right to request additional information prior to extending service registration. CHIPA will provide an explanation of action(s) that must be taken to complete a clinical review for continued services.

5.4. Termination of Outpatient Care

CHIPA and Beacon require that all outpatient providers set specific termination goals and discharge criteria for members. Providers are encouraged to use the LOCC documented in Appendix A (also accessible through eServices or by contacting provider.inquiry@beaconhealthoptions.com) to determine whether the service meets medical necessity for continuing outpatient care.

5.5. Decision and Notification Time Frames

CHIPA is required by the state, federal government and NCQA to render utilization review decisions in a timely manner to accommodate the clinical urgency of a situation. CHIPA has adopted the strictest time frame for all UM decisions in order to comply with the various requirements.

The time frames below present the internal time frames for rendering a UM determination, and notifying members of such determination. All time frames begin at the time of receipt of the request. Please note; the maximum time frames may vary from those on the table below on a case-by-case basis in accordance with state, federal government, NCQA or URAC requirements that have been established for each line of business.

TABLE 5-4: DECISION AND NOTIFICATION TIME FRAMES

	TYPE OF DECISION	DECISION TIME FRAME	VERBAL NOTIFICATION	WRITTEN NOTIFICATION
Pre-Service Review				
Initial Request for Urgent Mental Health Services	Urgent	Within 72 hours	Within 24 hours of making the decision, not to exceed 72 hours	Within 72 hours of the receipt of the request
Initial Request for Non-Urgent Mental Health Services	Standard	Within 5 business days	Within 24 hours of making the decision	Within 2 business days of making the decision
Concurrent Review				
Continued Request for Non-Urgent Mental Health Services	Non-Urgent/ Standard	Within 5 business days	Within 24 hours of making the decision	Within 2 business days of making the decision
Post-Service				

	TYPE OF DECISION	DECISION TIME FRAME	VERBAL NOTIFICATION	WRITTEN NOTIFICATION
Request for Mental Health Services Already Rendered	Non-Urgent/ Standard	Within 30 calendar days	Within 30 calendar days	Within 30 calendar days of receipt of request

Note: The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

When the specified time frames for standard and expedited prior authorization requests expire before CHIPA makes a decision, an adverse action notice will go out to the member on the date the time frame expires.

Chapter 6

Clinical Reconsiderations and Appeals

Members and their legal guardian have the right to appeal CHIPA's decision not to authorize care at the requested level of care. All medical necessity reconsiderations and/or appeals are managed by Beacon.

For questions on provider dispute resolutions, please refer to that section in Chapter 7 on Billing Transactions.

6.1. Request for Reconsideration of Adverse Determination

If a member or member's provider disagrees with a utilization review decision issued by CHIPA, the member, his/her authorized representative, or the provider may request reconsideration. Please call CHIPA promptly upon receiving notice of the denial for which reconsideration is requested.

A peer review conversation may be requested at any time by the treating provider, and may occur prior to or after an adverse determination, upon request for a reconsideration. CHIPA UR clinicians and physician advisors are available daily to discuss denial cases by phone at 855.765.9702.

When reconsideration is requested, a physician advisor will review the case based on the information available and will make a determination within one business day. If the member, member representative or provider is not satisfied with the outcome of reconsideration, he or she may file an appeal on behalf of the member.

6.2. Clinical Appeals Process

A member and/or the member's appeal representative or provider (acting on behalf of the member) may appeal an adverse action/adverse determination. Both clinical and administrative denials may be appealed. Appeals may be filed either verbally, in person, or in writing.

Every appeal receives fair consideration and timely determination by a CHIPA employee who is a qualified professional. CHIPA conducts a thorough investigation of the circumstances and determination being appealed, including fair consideration of all available documents, records, and other information without regard to whether such information was submitted or considered in the initial determination. Punitive action is never taken against a provider who requests an appeal or who supports a member's request for an appeal.

PEER REVIEW

For all acute and diversionary levels of care, adverse determinations are rendered by board-eligible or board-certified psychiatrists of the same or similar specialty as the services being denied. A peer review conversation may also be requested at any time by the treating provider, and it may occur prior to an adverse determination or after, upon request for a reconsideration.

URGENCY OF APPEAL PROCESSING

Appeals can be processed on a standard or an expedited basis, depending on the urgency of the need for a resolution. All initial appeal requests are processed as standard appeals unless the definition of urgent care is met, in which case the appeal would be processed as an expedited internal appeal. If the member, provider or other member representative is not satisfied with the outcome of an appeal, he or she may proceed to file for a State Fair Hearing.

DESIGNATION OF AUTHORIZED MEMBER REPRESENTATIVE (AMR)

If the member is designating an appeal representative to appeal on his or her behalf, the member must complete and return a signed and dated *Designation of Appeal Representative Form* prior to CHIPA's deadline for resolving the appeal. In cases where the appeal is expedited, a provider may initiate appeal without written consent from the member.

APPEALS PROCESS DETAIL

This section contains detailed information about the appeal process for members:

The table below illustrates:

- How to initiate an appeal
- AMR information
- Resolution and notification time frames for expedited and standard clinical appeals, and external reviews

MEDI-CAL APPEALS PROCESS

EXPEDITED CLINICAL APPEALS	STANDARD CLINICAL APPEALS	EXTERNAL APPEALS
1. The member, or his or her authorized representative, have 90 days (or 10 days to ensure continuation of currently authorized services) from receipt of the notice of action or the intended effective date of the proposed action. The provider may act as the member's appeal representative (AMR) without completing the Designation of Appeal Representative Form. The provider can file an expedited appeal on behalf of the member regardless of the services. 2. A CHIPA physician advisor, who has not been involved in the initial decision, reviews all available information and attempts to speak with the member's attending physician.	1. The members, their legal guardian, or AMR have up to 90 days to file an appeal after notification of CHIPA's adverse determination. 2. A CHIPA physician advisor, not involved in the initial decision, will review available information and attempt to contact the member's attending physician/provider. 3. Resolution and notification will be provided within 30 calendar days of the appeal request. 4. If the appeal requires review of medical records (post-service situations), the member's or AMR's signature is required on an Authorization to Release Medical Information Form authorizing the release of medical and treatment	Members have the right to file a fair hearing request with the California Department of Social Services (CDSS) upon receipt of an adverse action issued by CHIPA. 1. The member may represent him/ herself at the fair hearing, or name someone else to be his/ her representative. 2. Members have the right to request an expedited Fair Hearing if the member meets the definition of urgent care defined above. 3. The request must be filed within 90 calendar days from the date on the adverse action letter sent by CHIPA. 4. If the appeal goes to State Fair Hearing, CHIPA and Gold Coast Health Plan representatives present the

MEDI-CAL APPEALS PROCESS		
EXPEDITED CLINICAL APPEALS	**STANDARD CLINICAL APPEALS**	**EXTERNAL APPEALS**
3. A decision is made within 72 hours of the initial request. 4. Throughout the course of an appeal for services previously authorized by Beacon, the member shall continue to receive services without liability until notification of the appeal resolution, provided the appeal is filed on a timely basis.	information relevant to the appeal. If the medical record with the *Authorization to Release Medical Information Form* is not received prior to the deadline for resolving the appeal, a resolution will be rendered based on the information available. Throughout the course of an appeal for services previously authorized by CHIPA, the member shall continue to receive services without liability until notification of the appeal resolution, provided the appeal is filed on a timely basis.	action taken and basis or reason for the action. 5. The member or his/her representative then responds with the reason he/she feels the decision was not correct, and why he/she needs the type and level of service in dispute, or why CHIPA should pay for a service already received. 6. The decision is made by CDSS, and the order is sent to CHIPA. CHIPA will comply with the final decision in the State Fair Hearing promptly and as expeditiously as the member's health condition requires.
Contact Information: Appeals requests can be made by calling CHIPA's appeals coordinator at 855.765.9702.	**Contact Information:** Appeals requests can be made by calling CHIPA's appeals coordinator at 855.765.9702 or in writing to: College Health IPA 5665 Plaza Drive, Suite 400 Cypress, CA 90630	**Contact Information:** Members or their AMR should contact CDSS at 800.952.5253 (TDD 800.952.8349) or write to: California Department of Social Services State Hearing Division P.O. Box 944243, MS 9-17-37 Sacramento, CA 94244-2430

6.3. Administrative Appeals Process

A provider may submit an administrative appeal when CHIPA denies payment based on the provider's failure to following administrative procedures for authorization. (Note that the provider may not bill the member for any services denied on this basis.) Please refer to Provider Dispute Resolution (PDR) information under Chapter 7.

Providers may also submit administrative appeals when services are denied based on administrative reasons and not based on medical necessity (e.g., request for services not covered by CHIPA). Providers must submit their appeal concerning administrative denials to CHIPA/Beacon Ombudsperson or Appeals

Coordinator no later than 365 days from the date of their receipt of the administrative denial decision. The provider should submit in writing the nature of the grievance and documentation to support an overturn of CHIPA's initial decision and provide any supporting documents that may be useful in making a decision. (Do not submit Medical Records or any clinical information.) CHIPA reviews the appeal, and a decision is made within 20 business days of date of receipt of the appeal. A written notification is sent within three business days of the appeal determination.

Chapter 7

Billing Transactions

This chapter presents all information needed to submit claims to Beacon. Beacon strongly encourages providers to rely on electronic submission, either through EDI or eServices in order to achieve the highest success rate of first-submission claims.

7.1. General Claims Policies

Beacon requires that providers adhere to the following policies with regard to claims:

DEFINITION OF "CLEAN CLAIM"

A clean claim, as discussed in this provider manual, the Provider Services Agreement, and in other Beacon informational materials, is defined as one that has no defect and is complete, including required, substantiating documentation of particular circumstance(s) warranting special treatment without which timely payments on the claim would not be possible.

ELECTRONIC BILLING REQUIREMENTS

The required edits, minimum submission standards, signature certification form, authorizing agreement and certification form, and data specifications as outlined in this manual must be fulfilled and maintained by all providers and billing agencies submitting electronic media claims to Beacon.

PROVIDER RESPONSIBILITY

The individual provider is ultimately responsible for accuracy and valid reporting of all claims submitted for payment. A provider using the services of a billing agency must ensure through legal contract (a copy of which must be made available to Beacon upon request) the responsibility of a billing service to report claim information as directed by the provider in compliance with all policies stated by Beacon.

LIMITED USE OF INFORMATION

All information supplied by Beacon or collected internally within the computing and accounting systems of a provider or billing agency (e.g., member files or statistical data) can be used only by the provider in the accurate accounting of claims containing or referencing that information. Any redistribution or dissemination of that information by the provider for any purpose other than the accurate accounting of behavioral health claims is considered an illegal use of confidential information.

PROHIBITION OF BILLING MEMBERS

Providers are not permitted to bill Gold Coast Health Plan members under any circumstances for covered services rendered, excluding share of cost when appropriate. See Chapter 3, Prohibition on Billing Members, for more information.

BEACON'S RIGHT TO REJECT CLAIMS

At any time, Beacon can return, reject or disallow any claim, group of claims, or submission that does not meet HIPAA standards for EDI claims or that is missing information necessary for correct adjudication of the claim.

RECOUPMENTS AND ADJUSTMENTS BY BEACON

Beacon reserves the right to recoup money from providers due to errors in billing and/or payment, at any time. In that event, Beacon applies all recoupments and adjustments to future claims processed and report

such recoupments and adjustments on the EOB with Beacon's record identification number (REC.ID) and the provider's patient account number.

CLAIMS TURNAROUND TIME

All clean claims will be adjudicated within 30 calendar days from the date on which Beacon or Gold Coast Health Plan receives the claim. Gold Coast Health Plan will forward to Beacon, within 10 calendar days of receipt, all claims received by Gold Coast Health Plan that are the responsibility of Beacon. The date that the claim is received at Gold Coast Health Plan shall be used by Beacon as the date that the claim is received.

7.2. Coding

When submitting claims through eServices, users will be prompted to include appropriate codes in order to complete the submission, and drop-down menus appear for most required codes. Please see Beacon's EDI Transactions – 837 Companion Guide for placement of codes on the 837 file. Please note the following requirements with regard to coding.

- Providers are required to submit HIPAA-compliant coding on all claim submissions; this includes HIPAA-compliant revenue, CPT, HCPCS and ICD-10 codes. Beacon accepts only ICD-10 diagnosis codes as listed and approved by CMS and HIPAA. In order to be considered for payment by Beacon, all claims must have a Primary ICD-10 diagnosis. The ICD-10 coding for Mental, Behavioral and Neurodevelopmental Disorders are included in the range from F01 – F99. All diagnosis codes submitted on a claim form must be a complete diagnosis code with appropriate digits.
- Benefit configuration may vary by health plan. Providers should refer to their exhibit A for a complete listing of contracted, reimbursable procedure codes.

TIME LIMITS FOR FILING CLAIMS

Beacon must receive claims for covered services within the designated filing limit:

- Within 180 days of the dates of service on outpatient claims

Providers are encouraged to submit claims as soon as possible for prompt adjudication. Claims submitted after the 180-day filing limit will be subject to reduction in payment or denial per Medi-Cal regulations, unless submitted as a waiver or reconsideration request, as described in this chapter.

7.3. Coordination of Benefits (COB)

In accordance with The National Association of Insurance Commissioners (NAIC) regulations, Beacon coordinates benefits for behavioral health claims when it is determined that a person is covered by more than one health plan, including Medicare:

- When it is determined that Beacon is the secondary payer, claims must be submitted with a copy of the primary insurance's explanation of benefits report and received by Beacon within 180 days of the date on the EOB.
- Beacon reserves the right of recovery for all claims in which a primary payment was made prior to receiving COB information that deems Beacon the secondary payer. Beacon applies all

recoupments and adjustments to future claims processed, and reports such recoupments and adjustments on the EOB.

7.4. Provider Claims Dispute Resolution (PDR) Process

Both contracting and non-contracting providers have the right to file a Provider Dispute Resolution request. A provider dispute is a provider's written notice to Gold Coast Health Plan challenging, appealing or requesting reconsideration of:

- A claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested
- Seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered)
- Disputing a request for reimbursement of an overpayment of a claim
- Disputing a denial for authorization of payment for not following correct authorization procedures in requesting services

Each provider dispute must contain, at a minimum, the following information: provider's name, billing provider's tax ID number or provider ID number, provider's contact information, and:

1. If the provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from Beacon to a provider, the following must be provided: original claim form number (located on the RA), a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect
2. If the provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue
3. If the provider dispute involves a patient or group of patients, the name and identification number(s) of the patient or patients, a clear explanation of the disputed item, including the date of service and provider's position on the dispute, and a patient's written registration for provider to represent said patients.
4. Non-contracting providers are also required to submit a completed and signed Waiver of Liability Notice which is available on our website at www.beaconhealthoptions.com.

All inquiries regarding the status of a provider dispute or about filing a provider dispute or other inquiries must be directed to the Provider Dispute Department at 855.765.9702, option 4, then 4.

HOW TO SEND A PROVIDER DISPUTE TO BEACON

Provider disputes submitted to Beacon must include the information listed above, for each provider dispute. To facilitate resolution, the clinician may use either the *Provider Dispute Resolution Request Form*, available on our website at www.beaconhealthoptions.com, or a personalized form to submit the required information.

All provider disputes must be sent by either fax to 877.563.3480, by email to providerdisputes@beaconhs.com, or by mail to the attention of Provider Disputes at the following:

Beacon Provider Disputes
5665 Plaza Drive, Suite 400
Cypress, CA 90630

INSTRUCTIONS FOR FILING SUBSTANTIALLY SIMILAR CLINICIAN DISPUTES

Substantially similar multiple claims, billing or contractual disputes, should be filed in batches as a single dispute, and may be submitted using either the *Provider Dispute Resolution Request – Multiple like Claims Form* or a personalized form with the required information.

TIMEFRAMES REGARDING PROVIDER DISPUTES

- **Contracted Providers** -- Contracted providers have up to 365 calendar days to file a dispute from the date of the initial payment determination.
- **Non-Contracted Providers** -- Non-Contracted providers have up to 120 calendar days to file a dispute from the date of initial payment determination. In addition, Non-Contracted Providers may submit a second level written request to the applicable health plan for a second level review, by email, fax or mail within 180 calendar days of written notice from Beacon.

Provider disputes that do not include all required information as set forth above may be returned to the submitter for completion. An amended provider dispute that includes the missing information may be submitted to Beacon within 45 calendar days of your receipt of a returned provider dispute.

ACKNOWLEDGMENT OF PROVIDER DISPUTES AND RESOLUTION

Beacon will provide a written acknowledgement of a dispute to the submitting provider within five days of receipt of the dispute. Beacon will issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 calendar days after the date of receipt of the provider dispute or the amended provider dispute.

PAST DUE PAYMENTS TO PROVIDER

If the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the clinician, Beacon will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five calendar days of the issuance of the written determination.

PROVIDER OUTREACH AND EDUCATION

In an effort to help providers that may be experiencing claims payment issues, Beacon runs quarterly reports identifying those providers that may benefit from outreach and education. Providers with low approval rates are contacted and offered support and documentation materials to assist in reconciliation of any billing issues that are having an adverse financial impact and ensure proper billing practices within Beacon's documented guidelines.

Beacon's goal in this outreach program is to assist providers in as many ways as possible to receive payment in full, based upon contracted rates, for all services delivered to members.

How the Program Works

- A quarterly approval report is generated that lists the percentage of claims paid in relation to the volume of claims submitted.

- All providers below 75% approval rate have an additional report generated listing their most common denials and the percentage of claims they reflect.
- An outreach letter is sent to the provider's billing director as well as a report indicating the top denial reasons. A contact name is given for any questions or to request further assistance or training.

CLAIMS INQUIRIES AND RESOURCES

Additional information is available through the following resources:

Online

- Chapter 2 of this Manual
- Beacon's Claims Page
- Read About eServices
- eServices User Manual
- Read About EDI
- EDI Transactions - 837 Companion Guide
- EDI Transactions - 835 Companion Guide
- EDI Transactions - 270-271 Companion Guide

Email Contact

- provider.inquiry@beaconhealthoptions.com
- e-support.services@beaconhealthoptions.com
- providerdisputes@beaconhs.com

Telephone

- Interactive Voice Recognition (IVR): 888.210.2018
  You will need your practice or organization's tax ID, the member's identification number and date of birth, and the date of service.
- Claims Hotline: 855.765.9702
  Hours of operation are 8:30 a.m. to 5 p.m., Monday through Friday.
- Beacon's Main Telephone Numbers

Provider Relations	855.765.9702, option 4, then 5
EDI	855.765.9702
TTY	800.735.2929

7.5. Electronic Submission of Claims

Providers are expected to complete claims transactions electronically through one of the following, where applicable:

- **Electronic Data Interchange (EDI)** supports electronic submission of claim batches in HIPAA-compliant 837P format for professional services and 837I format for institutional services. Providers may submit claims using EDI/837 format directly to Beacon or through a billing intermediary. If using

Office Ally as the billing intermediary, two identification numbers must be included in the 837 file for adjudication:

  - Beacon's payor ID is 43324.
  - Beacon's Gold Coast Health Plan ID is 103.

- **eServices** enables providers to submit inpatient and outpatient claims without completing a CMS 1500 or UB04 claim form. Because much of the required information is available in Beacon's database, most claim submissions take less than one minute and contain few, if any errors.
- **IVR** provides telephone access to member eligibility, claims status and authorization status.

7.6. Claims Transaction Overview

Table 7-1 below identifies all claim transactions, indicates which transactions are available on each of the electronic media, and provides other information necessary for electronic completion. Watch for updates as additional transactions become available on EDI, eServices and IVR.

TABLE 7-1: CLAIMS TRANSACTION OVERVIEW

TRANSACTION	ACCESS ON:			APPLICABLE WHEN:	TIME FRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
	EDI	ESERVICES	IVR			
Member Eligibility Verification	Y	Y	Y	Completing any claim transaction; and Submitting clinical authorization requests	N/A	N/A
Submit Standard Claim	Y	Y	N	Submitting a claim for authorized, covered services, within the timely filing limit	Within 90 days after the date of service	N/A
Resubmission of Denied Claim	Y	Y	N	Previous claim was denied for any reason except time filing	Within 180 days after the date on the EOB	▪ Claims denied for late filing may be resubmitted as reconsiderations ▪ Rec ID is required to indicate that

TRANSACTION	ACCESS ON:			APPLICABLE WHEN:	TIME FRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
	EDI	ESERVICES	IVR			
						claim is a resubmission.
180-day Waiver* (Request for waiver of timely filing limit)	N	N	N	A claim being submitted for the first time will be received by Beacon after the original filing limit, and must include evidence that one of the following conditions is met: ▪ Provider is eligible for reimbursement retroactively ▪ Member was enrolled in health plan retroactively ▪ Services were authorized retroactively ▪ Third party coverage is available and was billed first. (A copy of the other insurance explanation of benefits or payment is required.)	Within 180 days from the qualifying event	▪ Waiver requests will be considered only for these four circumstances. A waiver request that presents a reason not listed here will result in a claim denial on a future EOB. ▪ A claim submitted beyond the filing limit that does not meet the above criteria may be submitted as reconsideration request. ▪ Beacon's waiver determination is reflected on a future EOB with a message of "Waiver Approved" or "Waiver Denied": if waiver of the filing limit is approved, the claim appears

TRANSACTION	ACCESS ON:			APPLICABLE WHEN:	TIME FRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
	EDI	ESERVICES	IVR			
						adjudicated; if the request is denied, the denial reason appears.
Request for Reconsideration of Timely Filing Limit*	N	Y	N	Claim falls outside of all time frames and requirements for resubmission, waiver and adjustment.	Within 60 days from the date of payment or non-payment	Future EOB shows "Reconsideration Approved" or "Reconsideration Denied" with denial reason.
Request to Void Payment	N	N	N	Claim was paid to provider in error and Provider needs to return the entire paid amount to Beacon.	N/A	**Do NOT send a refund check to Beacon.**
Request for Adjustment	Y	Y	N	The amount paid to provider on a claim was incorrect Adjustment may be requested to correct: ▪ Underpayment (positive request) ▪ Overpayment (negative request)	Positive request must be received by Beacon within 180 days from the date of original payment. No filing limit applies to negative requests.	▪ ***Do NOT send a refund check to Beacon.*** ▪ ***A Rec ID is required to indicate that claim is an adjustment.*** ▪ Adjustments are reflected on a future EOB as recoupment of the previous (incorrect) amount, and if money is owed to provider, repayment of

TRANSACTION	ACCESS ON:			APPLICABLE WHEN:	TIME FRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
	EDI	ESERVICES	IVR			
						the claim at the correct amount. ▪ If an adjustment appears on an EOB and is not correct, another adjustment request may be submitted based on the previous incorrect adjustment. ▪ Claims that have been denied cannot be adjusted, but may be resubmitted.
Obtain Claim Status	N	Y	Y	Available 24/7 for all claims transactions submitted by provider	N/A	Claim status is posted within 48 hours after receipt by Beacon.
View/Print Remittance Advice (RA)	N	N	N	Available 24/7 for all claim transactions received by Beacon	N/A	Printable RA is posted within 48 hours after receipt by Beacon.

Please note that waivers and reconsiderations apply only to the claims filing limit; claims are still processed using standard adjudication logic, and all other billing and authorization requirements must be met. Accordingly, an approved waiver or reconsideration of the filing limit does not guarantee payment, since the claim could deny for another reason.

PAPER CLAIMS TRANSACTIONS

Providers are strongly discouraged from using paper claims transactions where electronic methods are available, and should be aware that processing and payment of paper claims is slower than that of electronically submitted claims. Electronic claim transactions take less time and have a higher rate of approval since most errors are eliminated.

For paper submissions, providers are required to submit clean claims on the National Standard Format CMS1500 or UB04 claim form. No other forms are accepted.

Mail paper claims to:

CHIPA/Beacon Claims Department
Gold Coast Health Plan
5665 Plaza Drive, Suite 400
Cypress, CA 90630

Beacon accepts claims transmitted by fax. The claims fax number is 877.563.3480

Beacon Discourages Paper Transactions

BEFORE SUBMITTING PAPER CLAIMS, PLEASE
REVIEW ELECTRONIC OPTIONS EARLIER IN THIS CHAPTER.

Paper submissions have more fields to enter,
a higher error rate/lower approval rate, and slower payment.

Professional Services: Instructions for Completing the CMS 1500 Form

Table 7-2 below lists each numbered block on the CMS 1500 form with a description of the requested information, and indicates which fields are required in order for a claim to process and pay.

Table 7-2: CMS 1500 Form

TABLE BLOCK #	REQUIRED?	DESCRIPTION
1	No	Check Applicable Program
1a	Yes	Member's Gold Coast Health Plan ID Number
2	Yes	Member's Name
3	Yes	Member's Birth Date and Sex
4	Yes	Insured's Name
5	Yes	Member's Address
6	No	Member's Relationship to Insured
7	No	Insured's Address
8	Yes	Member's Status

TABLE BLOCK #	REQUIRED?	DESCRIPTION
9	Yes	Other Insured's Name (if applicable)
9a	Yes	Other Insured's Policy or Group Number
9b	Yes	Other Insured's Date of Birth and Sex
9c	Yes	Employer's Name or School Name
9d	Yes	Insurance Plan Name or Program Name
10a-c	Yes	Member's Condition Related to Employment
11	No	Member's Policy, Group or FICA Number (if applicable)
11a	No	Member's Date of Birth (MM, DD, YY) and Sex (check box)
11b	No	Employer's Name or School Name (if applicable)
11c	No	Insurance Plan Name or Program Name (if applicable)
11d	No	Is there another health benefit plan?
12	Yes	Member's or Authorized Person's Signature and Date on File
13	No	Member's or Authorized Person's Signature
14	No	Date of Current Illness
15	No	Date of Same or Similar Illness
16	No	Date Client Unable to Work in Current Occupation
17	No	Name of Referring Physician or Other Source (if applicable)
17b	No	NPI of Referring Physician
18	No	Hospitalization dates Related to Current Services (if applicable)
19	Yes	Former Control Number (Record ID if applicable)
20	No	Outside Lab?
21	Yes	Diagnosis or Nature of Illness or Injury.
22	No	Medicaid Resubmission Code
23	Yes	Prior Authorization Number (if applicable)

TABLE BLOCK #	REQUIRED?	DESCRIPTION
24a	Yes	Date of Service
24b	Yes	Place of Service Code (HIPAA-compliant)
24d	Yes	Procedure Code (HIPAA compliant between 290 and 319) and Modifier, when applicable
24e	Yes	Diagnosis Pointer – 1, 2, 3, or 4
24f	Yes	Charges
24g	Yes	Days or Units
24h	No	EPSDT
24i	No	ID Qualifier
24j	Yes	Rendering Provider Name and Rendering Provider NPI
25	Yes	Federal Tax ID Number
26	No	Provider's Member Account Number
27	No	Accept Assignment (check box)
28	Yes	Total Charges
29	Yes	Amount Paid by Other Insurance (if applicable)
30	Yes	Balance Due
31	Yes	Signature of Physician/Practitioner
32	Yes	Name and address of facility where services were rendered (Site ID). If missing, a claims specialist will chose the site shown as 'primary' in beacon's database.
32a	No	NPI of Servicing Facility
33	Yes	Provider Name
33a	Yes	Billing Provider NPI
33b	No	Pay to Provider Beacon ID Number

PAPER RESUBMISSION

See Table 7-1 for an explanation of claim resubmission, when resubmission is appropriate, and procedural guidelines.

- If the resubmitted claim is received by Beacon more than 90 days from the date of service, the REC. ID from the denied claim line is required and may be provided in either of the following ways:
    - Enter the REC.ID in box 64 on the UB04 claim form or in box 19 on the CMS 1500 form
    - Submit the corrected claim with a copy of the EOB for the corresponding date of service.
- **The REC.ID corresponds with a single claim line on the Beacon EOB. Therefore, if a claim has multiple lines, there will be multiple REC.ID numbers on the Beacon EOB.**
- The entire claim that includes the denied claim line(s) may be resubmitted regardless of the number of claim lines; Beacon does not require one line per claim form for resubmission. When resubmitting a multiple-line claim, it is best to attach a copy of the corresponding EOB.
- Resubmitted claims cannot contain original (new) claim lines along with resubmitted claim lines.
- **Resubmissions must be received by Beacon within 90 days after the date on the EOB. A claim package postmarked on the 90th day is not valid.**
- If the resubmitted claim is received by Beacon within 90 days from the date of service, the corrected claim may be resubmitted as an original. A corrected and legible photocopy is also acceptable.

Paper Submission of *180-Day Waiver Form*

- See Table 7-1 for an explanation of waivers, when a waiver request is applicable, and procedural guidelines
- Watch for notice of waiver requests becoming available on eServices
- Download the *180-Day Waiver Form*
- Complete a *180-Day Waiver Form* for each claim that includes the denied claim(s), per the instructions below
- Attach any supporting documentation
- Prepare the claim as an original submission with all required elements
- Send the form, all supporting documentation, claim and brief cover letter to:

    CHIPA/Beacon Cypress
    Gold Coast Health Plan Claims Department
    5665 Plaza Drive, Suite 400
    Cypress, CA 90630-5023

Completion of the *90-Day Waiver Request Form*

To ensure proper resolution of your request, complete the *90-Day Waiver Request Form* as accurately and legibly as possible.

1. **Provider Name**
   Enter the name of the provider who provided the service(s)

2. **Provider ID Number**
   Enter the provider ID number of the provider who provided the service(s)
3. **Member Name**
   Enter the member's name
4. **Gold Coast Health Plan member ID number**
   Enter the plan member ID number
5. **Contact Person**
   Enter the name of the person whom Beacon should contact if there are any questions regarding this request
6. **Telephone Number**
   Enter the telephone number of the contact person
7. **Reason for Waiver**
   Place an "X" on all the line(s) that describe why the waiver is requested.
8. **Provider Signature**
   A 90-day waiver request cannot be processed without a typed, signed, stamped, or computer-generated signature. Beacon will not accept "Signature on file".
9. **Date**
   Indicate the date that the form was signed

PAPER REQUEST FOR ADJUSTMENT OR VOID

See Table 7-1 for an explanation of adjustments and voids, when these requests are applicable, and procedural guidelines.

- **Do not send a refund check to Beacon.** A provider, who has been incorrectly paid by Beacon, must request an adjustment or void.
- Prepare a new claim as you would like your final payment to be, with all required elements. Place the Rec.ID in box 19 of the CMS 1500 claim form, or box 64 of the UB04 form or;
- Download and complete the Adjustment/Void Request Form per the instructions below
- Attach a copy of the original claim
- Attach a copy of the EOB on which the claim was paid in error or paid an incorrect amount

Send the form, documentation and claim to:

CHIPA/Beacon Claims Department
Adjustment Requests
5665 Plaza Drive, Suite 400
Cypress, CA 90630-5023

To Complete the *Adjustment/Void Request Form*

To ensure proper resolution of your request, complete the Adjustment/Void Request Form as accurately and legibly as possible and include the attachments specified above.

1. **Provider Name**
   Enter the name of the provider to whom the payment was made

2. **Provider ID Number**
   Enter the Beacon provider ID number of the provider that was paid for the service. If the claim was paid under an incorrect provider number, the claim must be voided, and a new claim must be submitted with the correct provider ID number.
3. **Member Name**
   Enter the member's name as it appears on the EOB. If the payment was made for the wrong member, the claim must be voided, and a new claim must be submitted.
4. **Member ID Number**
   Enter the plan member ID number as it appears on the EOB. If a payment was made for the wrong member, the claim must be voided, and a new claim must be submitted.
5. **Beacon Record ID Number**
   Enter the record ID number as listed on the EOB.
6. **Beacon Paid Date**
   Enter the date the check was cut as listed on the EOB.
7. **Check Appropriate Line**
   Place an "X" on the line that best describes the type of adjustment/void being requested.
8. **Check all that Apply**
   Place an "X" on the line(s) that best describe the reason(s) for requesting the adjustment/void. If "Other" is marked, describe the reason for the request.
9. **Provider Signature**
   An adjustment/void request cannot be processed without a typed, signed, stamped, or computer-generated signature. Beacon will not accept "Signature on file."
10. **Date**
    List the date that the form is signed