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

L.A. Care Health Plan

This document contains chapters 1-7 of CHIPA/Beacon's Behavioral Health Policy and Procedure Manual for providers serving L.A. Care Health Plan Insurance members. Additionally, all referenced materials are available on this website. Chapters which contain all level of care service descriptions and criteria will be posted on eServices; to obtain a copy, please email provider.inquiry@beaconhealthoptions.com or call 1.877.344.2858.

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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 with College Health IPA and/or Beacon Health Strategies LLC.

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: Provider Participation in the CHIPA/Beacon Network
- Chapter 3: Members, Benefits and Member-Related Policies
- Chapter 4: Quality Management and Improvement Program
- Chapter 5: Care Management and Utilization Management
- Chapter 6: Clinical Reconsideration and Appeals
- Chapter 7: Billing Transactions
- Addendum 1: Medi-Cal Managed Care Expansion
- Addendum 2: Cal MediConnect

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 1.877.344.2858, option 2, option 3 then option 2.

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 L.A. Care and its members. For all other CHIPA-contracted health plans, please refer to the appropriate provider manual at www.chipa.com.

1.2. Introduction to the Beacon/CHIPA/L.A. Care Partnership

L.A. Care has contracted with Beacon Health Strategies LLC and College Health IPA to administer the delivery of behavioral health and substance use services for L.A. Care members. While Beacon is the contracted administrative service provider with L.A. Care, College Health IPA will render all utilization management determinations.

CHIPA'S RESPONSIBILITIES

CHIPA's responsibilities include:

1. Utilization Management: 24/7 utilization review and management for all inpatient, diversionary and outpatient behavioral health services for all enrolled members for all covered behavioral health services based on clinical protocols developed and approved by L.A. Care
2. Contracting of the professional network for outpatient care and attending physicians for higher levels of care

BEACON'S RESPONSIBILITIES

Beacon's responsibilities, for all product lines, include:

1. Contracting of facilities and programs for mental health and substance abuse higher levels of care
2. Network data maintenance
3. Provider relations
4. Provider credentialing and recredentialing
5. Claims processing and claims payment (Beacon will be paying claims on behalf of CHIPA.)
6. Quality management, improvement, and reporting, including HEDIS

1.3. Introduction to L.A. Care Health Plan

L.A. Care is a quasi-public health plan operating in L.A. County that was founded to serve California's Medi-Cal program. Today, L.A. Care has more than 1.1 million Medi-Cal enrollees and currently operates three other lines of business under state, federal or county contracts.

L.A. Care's Medi-Cal programs are not included in the management agreements with Beacon and CHIPA.

L.A. Care provides healthcare coverage through the following lines of business:

- Medi-Cal
- Personal Assistance Services Council (PASC-SEIU)
- Covered CA Health Benefits Exchange
- Cal MediConnect (Duals Demonstration)

1.4. Introduction to Beacon Health Strategies LLC

Beacon Health Strategies LLC is a limited liability, managed behavioral healthcare company. Established in 1996, Beacon's mission is to partner with our health plan customers and contracted providers to improve the delivery of behavioral healthcare for the members we serve.

Presently, Beacon provides care management services to more than 11 million members through its partnerships with client plans and care management organizations. Most often co-located at the physical location of our plan partners, Beacon's "in-sourced" approach deploys utilization managers, 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, behavioral 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 behavioral health with medical health.

1.5. Introduction to College Health IPA (CHIPA)

Since 1991, College Health IPA has provided utilization management for behavioral health services. Today, CHIPA currently serves more than 2.2 million members in California through its contracted network of more than 3,000 professional providers.

CHIPA is committed to providing behavioral health services with cultural sensitivity and superior customer service while maintaining our vision to improve the overall behavioral healthcare experience.

1.6. Beacon/L.A. Care Behavioral Health Program

The L.A. Care/Beacon behavioral health and substance use program provides members with access to a full continuum of behavioral health and substance use services 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.

1.7. Additional Resources and Information

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 800-397-1630 to check member eligibility, number of visits available and applicable co-payments, confirm authorization and get claim 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.
5. Call 1.877.344.2858, option 2, then 3 to speak with a Beacon representative.

Chapter 2

Provider Participation

2.1. Network Operations

Beacon's Network Operations Department is responsible for management of the CHIPA/Beacon behavioral health provider network for the L.A. Care 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 Standard Time (PST), Monday through Friday, at 1.877.344.2858 option 2, then option 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's Service Agreement (PSA) with Beacon/CHIPA. Participating providers agree to provide behavioral health and/ or substance use 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. Transactions and Communications with Beacon

Beacon's website, www.beaconhealthstrategies.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.

Use this link (https://provider.beaconhs.com/) 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 claim submission and eligibility verification directly by the provider to Beacon or via an intermediary. For information about testing and setup for EDI, download Beacon's 837 & 835 companion guides.

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

For technical and business-related questions, email e-supportservices@beaconhealthoptions.com. To submit EDI claims through an intermediary, contact the intermediary for assistance. If using Office Ally, use Beacon's Office Ally Payer ID 43324 and Beacon's L.A. Care Plan ID 053.

TRANSACTION/ CAPABILITY	AVAILABLE 24/7	
	ESERVICES	EDI
Verify Member Eligibility, Benefits, and Copayment	Yes	Yes (HIPAA 270/271)
Check Number of Visits Available	Yes	Yes (HIPAA 270/271)
Submit Authorization Requests	Yes	No
View Authorization Status	Yes	No
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)

TRANSACTION/ CAPABILITY	AVAILABLE 24/7	
	ESERVICES	EDI
View Claims Status and Print EOBs	Yes	Yes (HIPAA 835)
Print Claims Reports and Graphs	Yes	No
Download Electronic Remittance Advice	Yes	Yes (HIPAA 835)
EDI Acknowledgment and Submission Reports	Yes	Yes (HIPAA 835)
Pend Authorization Requests for Internal	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 Relations at provider.inquiry@beaconhealthoptions.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 protected health information in non-secure email through the internet.

2.4. Appointment Access Standards

APPOINTMENT STANDARDS AND AFTER HOURS ACCESSIBILITY

TYPE OF APPOINTMENT/ SERVICE	APPOINTMENT MUST BE OFFERED:
General Appointment Standards	

TYPE OF APPOINTMENT/ SERVICE	APPOINTMENT MUST BE OFFERED:
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
All Other Outpatient Services	Within 7 calendar days
Aftercare Appointment Standards ***(Inpatient and 24-hour diversionary services must schedule an aftercare follow-up prior to a member's discharge)***	
Non-24-hour Diversionary	Within 2 calendar days
Psychopharmacology Services/ Medication Management	Within 10 business days

SERVICE AVAILABILITY AND HOURS OF OPERATION

SERVICE AVAILABILITY	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 a week ▪ Outpatient facilities, physicians, and practitioners are expected to provide these services during operating hours ▪ After hours, providers should have a live telephone answering services 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	▪ Beacon is required to make outpatient 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.

SERVICE AVAILABILITY	HOURS OF OPERATION
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 1.877.344.2858 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 1.877.344.2858.
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 the agency are sensitive to the diverse needs of L.A. Care members. Contracted providers are expected to provide services in a culturally competent manner at all times and to contact Beacon immediately if they are referred a member with cultural and/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 have 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. View Locate-a-Provider.

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:

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 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 restriction on treating members	Yes	Yes

TYPE OF INFORMATION	METHOD OF NOTIFICATION	
	eSERVICES	EMAIL
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 the location and capabilities of the new site, service, or program. See additional information below	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 Provider.inquiry@beaconhealthoptions.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 re-credentialing 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.

CREDENTIALING PROCESS

INDIVIDUAL PRACTITIONER CREDENTIALING	ORGANIZATIONAL CREDENTIALING
Beacon individually credentials and recredentials the following categories of clinicians in private or solo or practice settings: ▪ Psychiatrists ▪ 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	Beacon credentials and recredentials facilities and licensed outpatient agencies as organizations. Facilities that must be credentialed by Beacon as organizations include: ▪ Licensed outpatient clinics and agencies, including hospital-based clinics ▪ Federally Qualified Health Centers (FQHC) Rural Health Center (RHC), accredited and non-accredited ▪ Freestanding inpatient behavioral health facilities – freestanding and within general hospital ▪ Inpatient behavioral health units at general hospitals ▪ Inpatient detoxification facilities ▪ Other diversionary behavioral health and substance use services including: 1. Partial hospitalization 2. Day treatment 3. Intensive outpatient 4. Residential 5. Substance use rehabilitation

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 specified health plans.

ORGANIZATIONAL CREDENTIALING

In order to be credentialed, facilities and federally qualified healthcare centers (FQHC) 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 re-credentialing. If the facility or FQHC 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 facility or FQHC/RHC. If the facility or FQHC/RHC is not accredited by one of these accreditation organizations, Beacon conducts a site visit prior to rendering a credentialing decision.

The credentialed facility or FQHC/RHC is responsible for credentialing and overseeing its clinical staff as Beacon does not individually credential facility-based staff. 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, Licensed Marriage and Family Therapist, a licensed Psychologist, a licensed master's-level clinical Nurse Specialist, or 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; and
- Absence of Medicare/Medicaid sanctions.

Once the facility or FQHC/RHC has been approved for credentialing and contracted with Beacon/CHIPA to serve members of one or more health plans, all licensed or certified behavioral health professionals listed may treat members in the facility or FQHC/RHC 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
- Cal MediConnect (CMC) Training – to be completed by providers contracted for CMC lines of business, prior to seeing Beacon members in lieu of the New Provider Orientation

To obtain a copy of these trainings, please contact Provider Relations by email at provider.inquiry@beaconhealthoptions.com or by phone at 1.877.344.2858. Provider Relations also sends out an electronic quarterly survey in which all providers are expected to participate in.

Chapter 3

Member, Benefits, and Member-Related Policies

3.1. Behavioral Health and Substance Use Benefits

L.A. Care offers benefit programs to members enrolled in the PASC-SEIU, Cal MediConnect (Duals Demonstration), and California Health Exchange lines of business. The Medi-Cal mental health benefits program is described separately in Addendum 1.

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

- Inpatient detoxification
- Substance use rehabilitation
- Inpatient behavioral health
- Traditional outpatient behavioral health treatment
- Traditional outpatient substance use treatment
- Crisis stabilization bed
- Partial Hospital Program (PHP)
- Intensive Outpatient Program (IOP)
- Ambulatory detoxification
- Community support
- Emergency services
- Psychological and neuropsychological testing

OUTPATIENT BENEFITS

Access

Outpatient behavioral health treatment is an essential component of a comprehensive healthcare delivery system. Plan members may access outpatient behavioral health and substance use services by self-referring to a network provider, by calling Beacon, or by referral through acute or emergency room encounters. Members may also access outpatient care by referral from their primary care practitioner (PCP); however, a PCP referral is never required for behavioral health services.

Initial Encounters

Members are allowed access to initial therapy sessions without prior authorization. These sessions must be provided by contracted in-network providers, and are subject to meeting medical necessity criteria and benefit limitations.

To ensure payment for services, providers are strongly encouraged to ask new patients if they have been treated by other therapists. Via eServices, providers can look up the eligibility, services authorized and number of sessions that have been billed to Beacon; however, the member may have used additional visits that have not been billed. To ensure coverage, the new provider is encouraged to verify eligibility and obtain authorization before beginning treatment.

L.A. Care Behavioral Health Benefits

- Outpatient services do not require authorization; however, it's the provider's responsibility to ensure the member is eligible at the time of service.
- Some specialty outpatient services, TMS do require prior authorization. See Chapter 5 for authorization procedures.
- Benefits do not include payment for healthcare services that are not medically necessary or that exceed the benefit limit.
- 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.

Inpatient behavioral health and substance use benefits:

- Authorization is required for all services except emergency services*.

**See Chapter 5 for authorization procedures.*

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

Beacon members have the role to:

- Give us and your providers the information needed to help you get the best possible care.
- Follow the health care plan that you agreed on with your health care provider.

- Talk to your provider before changing your treatment plan.
- Understand your health problems as well as you can. Work with your health care providers to make a treatment plan that you all agree on.
- Read all information about your health benefits and ask for help if you have questions.
- Follow all health plan rules and policies.
- Choose an In-Network primary care physician, also called a PCP, if your health plan requires it.
- Tell your health plan or Beacon of any changes to your name, address or insurance.
- Contact your provider when needed, or call 911 if you 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 guardian 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 healthcare provider to appeal on their behalf according to the same procedures.

Right to Submit a Complaint or Concern to L.A. Care Health Plan

Members and their legal guardians have the right to file a complaint or grievance with L.A. Care regarding any of the following:

- The quality of care delivered to the member by a Beacon/CHIPA contracted provider
- The CHIPA utilization review process
- The quality of service delivered by any Beacon staff member or CHIPA/Beacon-contracted provider
- Members and their legal guardians may call L.A. Care directly to file a complaint, or they may call Beacon at 1.877.344.2858 to request assistance in filing a complaint with their 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 1.877.344.2858 or by TTY at 1.800.735.2929.

Prohibition on Billing Members

Health plan members may not be billed for any covered service or any balance after reimbursement by Beacon except for any applicable co-payment or 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

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.)

POSTING MEMBER RIGHTS AND 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

3.3. 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 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.

3.4. 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. A sample form is available here (See Provider Tools web page) or providers may use their own form; the form must allow the member to limit the scope of information communicated.

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 health plan medical and disease management programs and accepts referrals for behavioral health care management from the 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 the 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.

3.5. L.A. Care Member Eligibility

L.A. CARE 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.

An L.A. Care member card contains the following information:

- Member's ID name
- Effective date
- Member language
- Assigned PCP, medical group and hospital

Possession of a 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:

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 and then contact edi.operations@beaconhs.com	1.888.210.2018 Beacon's Interactive Voice Recognition (IVR)

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 L.A. Care 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.

Telehealth may apply to all outpatient codes listed within the provider services agreement (PSA) including psychotherapy and all E & M codes. Coverage is determined by the executed PSA.

Claims for services performed via telehealth must include the Healthcare Common Procedure Coding System (HCPCS) modifier "GT" (via interactive audio and video telecommunications systems). **NOTE**: Beginning October 1, 2019, the modifier required will change to 95 with a place of service code 02. According to DHCS guidelines, Q3014 for originating site is to be billed once per day for the same recipient and provider. In addition, T1014 is to be billed a maximum of 90 minutes per day (1 unit = 1 minute). Only one eligible provider may be reimbursed per member per date of service for a service provided through telehealth unless it is medically necessary for the participation of more than one provider. While these services do not require prior authorization, the provider must first be approved as a Telehealth provider by Beacon and must have a signed provider attestation on-file with Beacon.

Reimbursement for these services is subject to the same restrictions as face-to-face contacts as described in this provider manual.

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/Quality Improvement

Beacon utilizes a Continuous Quality Improvement (CQI) philosophy through which Beacon directly or through its authorized designees, monitors and evaluates appropriateness of care and service, identifies opportunities for improving quality and access, establishes quality improvement initiatives, and monitors resolution of identified problem areas. This includes monitoring and evaluation of services performed by Beacon or its designees, as well as behavioral health services rendered by providers and participating providers.

Beacon's comprehensive Quality Management Program (QMP) includes Quality Management (QM) policies and procedures applicable to all participating providers, strategies and major activities performed to provide for consistency and excellence in the delivery of services, includes a program description, an annual work plan that includes goals and objectives and specific QM related activities for the upcoming year and evaluation of the effectiveness of those activities. Participating providers are responsible for adhering to the QMP and are encouraged to provide comments to Beacon regarding ongoing QMP activities through direct telephone communications and/or via the Provider website. Beacon requires each provider to also have its own internal QM and I Program to continually assess quality of care, access to care, and compliance with medical necessity criteria.

Quality Management Committees

The Beacon Enterprise Clinical and Quality Oversight Committee (BECQOC), has ultimate accountability for the oversight and effectiveness of the QMP. The Corporate Quality Committee (CQC) is the body responsible for coordinating all corporate level quality management activities and providing oversight, direction, and consultation to the Region or Engagement Center QM committees as well as specific quality management programs. Beacon Region or Engagement Center QM committees are responsible for oversight of the day-to-day operations of their specific QM programs that includes reporting and communication of their activities and findings to the CQC as well as incorporating activities in their Region or Engagement Center as part of oversight monitoring responsibilities.

Certain functional areas within Beacon (e.g., claims) maintain quality management programs specific to the activities and services performed. Quality programs within functional areas are responsible for coordinating their quality management programs with the overarching QMP by communicating their findings and activities to the CQC and incorporating activities into their respective QMP.

The CQC reviews and approves the Corporate QM Program Description, QM Program Evaluation, and integrated QM/UM Work plan at least annually and at the time of any revision. The CQC receives a quarterly summary of all QM activities included in the work plan.

4.1. Quality Management/Quality Improvement Program Overview

The Beacon Corporate Quality Management Program (QMP) monitors and evaluates quality across the entire range of services provided by the company. Along with the trending of quality issues at the Region or Service Center level, the corporate QMP is intended to ensure that structure and processes are in place to lead to desired outcomes for members, clients, providers/participating practitioners, and internal clients.

The scope of the Corporate QMP includes:

a. Clinical services and Utilization Management Programs

b. Supporting improvement of continuity and coordination of care

c. Case Management/Intensive Case Management/Targeted Case Management

d. Quality Improvement Activities (QIAs)/Projects (QIPs)

e. Outcome Measurement and data analysis

f. Network Management/Provider Relations Activities

g. Member Experience Survey

h. Clinical Treatment Record Evaluation

i. Service Availability and Access to Care

j. Practitioner and Provider Quality Performance

k. Annually evaluating member Complaints and Grievances (Appeals) using valid methodology

l. Member Rights and Responsibilities

m. Patient Safety Activities (including identification of safety issues during prospective reviews)

n. Clinical and Administrative Denials and Appeals

o. Performance Indicator development and monitoring activities

p. Health Literacy and Cultural Competency assurance

q. Compliance with Section 1557, nondiscrimination law in the Affordable Care Act (ACA)

r. Promotion of e-technologies to improve member access and understanding of health benefits

s. Promotion of the use of member self-management tools

t. Screening Programs

u. Complaints and Grievances

Several of the above activities and processes are described in greater detail in other sections of this handbook.

4.2. Role of Participating Providers

Participating practitioners/providers are informed about the QMP via the Beacon Provider Handbook, provider newsletters, website information, direct mailings, email provider alerts, seminars and training programs. Many of these media venues provide network practitioners/providers with the opportunity to be involved and provide input into the QM and UM Programs. Additional opportunities to be involved include representation on the National Credentialing and Provider Appeals Sub-Committees as well as on various

committees and sub-committees and/or workgroups at the Regional or or Engagement Center level (e.g., Credentialing Committee and Clinical Advisory Committees). Involvement includes, but is not limited to:

- Providing input into the Beacon/CHIPA medical necessity criteria
- Providing peer review and feedback on proposed practice guidelines, clinical quality monitors and indicators, new technology and any critical issues regarding policies and procedures of Beacon
- Reviewing QIAs and making recommendations to improve quality of clinical care and services
- Reviewing, evaluating, and making recommendations for the credentialing and re-credentialing of participating practitioners and organizational providers
- Reviewing, evaluating and making recommendations regarding sanctions that result from participating practitioner and organizational provider performance issues
- As part of the QMP, Beacon incorporates principles designed to encourage the provision of care and treatment in a culturally competent and sensitive manner. These principles include:
- Emphasis on the importance of culture and diversity
- Assessment of cross-cultural relations
- Expansion of cultural knowledge
- Consideration of sex and gender identity
- Adaptation of services to meet the specific cultural and linguistic needs of members.

Participating providers are reminded to take the cultural background and needs of members into account when developing treatment plans and/or providing other services.

To participate in CHIPA's Provider Advisory Council, email provider.inquiry@beaconhs.com.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 caresatisfaction 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 AND GUIDELINES

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 (CMMC) for final approval. Each year, Beacon measures providers' adherence to at least three (3) Clinical Practice Resources. 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 the 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.

4.7. Continuity and Coordination of Care

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 transitional care for up to 12 months from the date of their enrollment with L.A. Care, 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.

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 OP 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 and the Behavioral Health-PCP Communication Form available for initial communication and subsequent updates, posted on the website, or their own form that includes the following information: ▪ Presenting problem/reason for admission ▪ Date of admission ▪ Admitting diagnosis ▪ Preliminary treatment plan ▪ Currently prescribed medications ▪ Proposed discharge plan	With the member's informed consent, acute care facilities should 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 3 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 should make every effort to provide the same notifications and information to the member's outpatient therapist, if there is one. Acute care providers' communication requirements are addressed during continued stay and discharge reviews and documented in Beacon's member record.

COMMUNICATION BETWEEN OUTPATIENT BEHAVIORAL HEALTH PROVIDERS AND PCPS, OTHER TREATERS	COMMUNICATION BETWEEN INPATIENT/DIVERSIONARY PROVIDERS AND PCPS, OTHER OUTPATIENT TREATERS
▪ Behavioral health provider contact name and telephone number ▪ Request for PCP response by fax or mail within 3 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 ▪ Any other medically relevant information Outpatient providers' compliance with communication standards is monitored through requests for authorization submitted by the provider, and through chart reviews.	

4.9. 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 result 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 that 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 the health plan in order to initiate the appropriate investigation. The plan will then report suspected fraud or abuse in writing to the correct authorities.

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:

1. Presents (or causes to be presented) to the federal government a false or fraudulent claim for payment or approval
2. Uses (or causes to be used) a false record or statement to get a claim paid by the federal government
3. Conspires with others to get a false or fraudulent claim paid by the federal government
4. 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 healthcare terms includes the amount paid for each false claim that is filed.

4.10. *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 his or her 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 his or her 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 1.877.344.2858 and ask to speak to the Compliance Officer.

4.11. Complaints

Providers with complaints or concerns should contact Beacon at 1.877.344.2858, option 6, then 3 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 the plan directly.

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.

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 Reconsideration and Appeals in Chapter 6.

Chapter 5

Care Management and Utilization Management

5.1. Care Management

Beacon's Care Management program , through collaboration with members and their treatment providers, PCPs, the plans medical case managers, and state agencies (DHCS, DCFS) is designed to ensure the coordination of care, including individualized assessment, care management planning, discharge planning and mobilization of resources to facilitate an effective outcome for members whose clinical profile or usage of service indicates that they are at high risk for readmission into 24-hour psychiatric or addiction treatment settings or are in need of coordination and support to manage behavioral health symptoms. The primary goal of the program is stabilization and maintenance of members in their communities through the provision of community-based support services. These community-based providers can provide short-term services designed to respond with maximum flexibility to the needs of the individual member. The intensity and amount of support provided is customized to meet the individual needs of members and will vary according to the member's needs over time.

When clinical staff or providers identify members who demonstrate medical co-morbidity (i.e., pregnant women), a high utilization of services, a need for additional support to connect to appropriate care or an overall clinical profile that indicates they are at high-risk for admission or readmission into a 24-hour behavioral health or substance use treatment setting, they may be referred to Beacon's Care Management program.

Criteria for CM Program include, but are not limited to, the following:

- Demonstrate behavioral symptoms consistent with a DSM or ICD diagnosis which requires and can reasonably be expected to respond to therapeutic intervention
- Require assistance in obtaining and coordinating behavioral health treatment and community resource or services
- Through the initial screening process is identified as mild to moderate status and not high-risk requiring potential hospitalization of long-term care intervention
- May have recently been hospitalized and in need of subsequent behavioral health treatment to support ongoing care needs
- The MCP has identified need for case management due to the existence of co-morbid medical and behavioral health conditions
- Member has a combination of persistent psychiatric symptoms and lack of family or social support along with inadequate outpatient treatment relationships
- Medical Care Consultation/Coordination – Members with significant health issues including chronic pain, co-existing disorder with possible behavioral health concerns are screened for service coordination needs and addressed by the interdisciplinary team

Care Management is a voluntary program, and member consent is required for participation. For further information on how to refer a member to care management services, please contact Beacon at 1.877.344.2858.

5.2. 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'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 (for psychiatric treatment and American Society of Addiction Medicine (ASAM) criteria for all substance use 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 under-utilization

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:

- 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.
- Expected to improve an individual's condition or level of functioning.
- Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs.
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.
- Reflective of a level of service that is safe, where no equally effective, more conservative, and less resource intensive treatment is available.
- Not primarily intended for the convenience of the recipient, caretaker, or provider.
- No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
- Not a substitute for non-treatment services addressing environmental factors.
- Reasonable and necessary to protect life, prevent illness or disability, or to ease pain through the diagnosis or treatment of disease, illness or injury

- 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.

Medically necessary services for **Commercial** lines of business (LOB) varies as noted below:

* Medically necessary treatment of a mental health or substance use disorder means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

* In accordance with the generally accepted standards of mental health and substance use disorder care.

* Clinically appropriate in terms of type, frequency, extent, site, and duration.

* Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

Mental Health Condition or Substance Use Disorder or Mental Disorder: a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

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. 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.

Effective 1/1/2021, Commercial lines of business (LOB) in California are required to utilize non-profit medical necessity criteria. CHIPA's Executive Committee has adopted the use of LOCUS/CALOCUS/ECSII and American Society of Addition Medicine (ASAM) criteria in response to this state requirement.

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 LOC. However, the individual's needs and characteristics of the local service delivery system are taken into consideration prior to the making of UM decisions.

5.3. 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.

TERM	DEFINITION
Adverse Determination	A decision to deny, terminate, or modify (an approval of fewer days, units or another level of care other than was requested, which the practitioner does not agree with) an admission, continued inpatient stay, or the availability of any other behavioral health care service, for ▪ Failure to meet the requirements for coverage based on medical necessity ▪ Appropriateness of healthcare setting and level of care effectiveness ▪ Health plan benefits For Medi-Cal members, an **Adverse Benefit Determination** is any of the following actions 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.

TERM	DEFINITION
	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 provider, 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	The following actions or inactions by CHIPA or the provider organization: ▪ CHIPA's denial, in whole or in part, of payment for a service failure to provide covered services in a timely manner in accordance with the waiting time standards ▪ CHIPA's denial or limited authorization of a requested service, including the determination that a requested service is not a covered service ▪ CHIPA's reduction, suspension, or termination of a previous authorization for a service ▪ CHIPA's denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute adverse actions, including, but not limited to, denials based on the following: ○ Failure to follow prior authorization procedures ○ Failure to follow referral rules ○ Failure to file a timely claim ▪ CHIPA's failure to act within the time frames for making authorization decisions ▪ CHIPA's failure to act within the time frames for making appeal decisions For Medi-Cal members, an **Adverse Action:** (Also known as Adverse Determination): Is 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: • A determination of a provided or proposed to be provided service that is deemed not medically necessary • The denial or limited authorization of a requested service, including the determination that a requested service is not a Covered Service; • The reduction, suspension, or termination of a previous authorization for a service; • The failure to act within the time frames for making authorization decisions specified by CMS and state regulations; and

TERM	DEFINITION
	• 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.
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
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 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.

5.4. Authorization Procedures and Requirements

This section describes the processes for obtaining authorization for inpatient, diversionary and outpatient levels of care, and for CHIPA's medical necessity determinations and notifications. In all cases, the treating provider, whether admitting facility or outpatient practitioner 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 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 1.888.210.2018.

5.5. Emergency Services

Emergency services are those physician and outpatient hospital services, procedures, and treatments, including psychiatric stabilization and medical detoxification from drugs or alcohol, needed to evaluate or stabilize an emergency medical condition. The definition of an emergency medical condition follows:

> *"…a medical* condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (a) placing the health of the person in serious jeopardy; (b) serious impairment to bodily functions; (c) serious dysfunction of any bodily organ or part; or (d a condition described in clause (i) or (ii) of section 1867(e)(1)(B) of the Social Security Act.."

Section 1371.4(c) of the California Health and Safety Code states payment for emergency services and care may be denied only if:

1) The emergency services and care were never performed;
2) The enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist.

Emergency care that are deemed to be medically necessary will not be denied; however, subsequent days do require pre-service authorization. The facility must notify CHIPA as soon as possible and no later than 24 hours after an emergency admission and/or learning that the member is covered by the health plan. If a provider fails to notify CHIPA of an admission, CHIPA may administratively deny any days that are not prior-authorized.

EMERGENCY SCREENING AND EVALUATION

Plan members must be screened for an emergency medical condition by a qualified behavioral health professional from the hospital emergency room, or by a Psychiatric Evaluation Team (PET). This process allows members access to emergency services as quickly as possible and at the closest facility or by the closest crisis team.

After the emergency evaluation is completed, the facility or program clinician should call CHIPA to complete a clinical review, if admission to a level of care that requires pre-certification is needed.

The facility/program clinician is responsible for locating a bed, but may request CHIPA's assistance. CHIPA may contact an out-of-network facility in cases where there is not a timely or appropriate placement available within the network. In cases where there is no in-network or out-of-network psychiatric facility available, CHIPA will authorize boarding the member on a medical unit until an appropriate placement becomes available.

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.

DISAGREEMENT BETWEEN CHIPA AND ATTENDING PHYSICIAN

For acute services, in the event that CHIPA's physician advisor (PA) and the emergency service physician do not agree on the service that the member requires, the emergency service physician's judgment shall prevail, and treatment shall be considered appropriate for an emergency medical condition, if such treatment is consistent with generally accepted principles of professional medical practice and is a covered benefit under the member's program of medical assistance or medical benefits.

AUTHORIZATION PROCEDURES AND REQUIREMENTS

	INPATIENT AND DIVERSIONARY SERVICES	OUTPATIENT SERVICES
Initial Assessment	CHIPA requires a face-to-face evaluation for all members who require admission to acute services. To the maximum extent feasible, all members must be screened by a qualified behavioral health professional or at the nearest emergency room prior to admission to: ▪ Inpatient behavioral health ▪ Partial hospitalization	As presented in Chapter 3, plan members are allowed routine mental health and substance use disorder office visits without authorization up to the benefit limit.

	INPATIENT AND DIVERSIONARY SERVICES	OUTPATIENT SERVICES
	▪ Intensive outpatient program (IOP) ▪ Inpatient substance use rehabilitation ▪ Inpatient detoxification (medically managed and medically monitored) ▪ Crisis stabilization bed ▪ Ambulatory detoxification	
Pre-Service	See the Information Due at Time of Review Table	
Services Requiring Authorization	▪ Inpatient services ▪ Electroconvulsive therapy during an inpatient stay and in outpatient settings ▪ Diversionary services ▪ Day treatment ▪ Psychological and neuropsychological testing - Download form ▪ Home-based therapy appointment – Download form ▪ Ambulatory detoxification – Call CHIPA 1. Providers must request approval from CHIPA prior to transferring members. The member must meet CHIPA's admission criteria for the receiving facility level of care prior to transfer. Without pre-service authorization for the receiving facility, elapsed days may not be reimbursed. 2. Out-of-network services are not a covered benefit. They may be authorized in some circumstances where needed care is not available within the network. 3. Emergency services do not require pre-service authorization; however, facilities must notify CHIPA of the emergency treatment and/or admission within 24 hours. 4. Routine outpatient medication management and psychotherapy services do not require pre-authorization, but are subject to quality review. 5. Providers must request approval from CHIPA prior to transferring members. The member must meet Beacon's admission criteria for the receiving facility prior to transfer. Without pre-service authorization for the	

	INPATIENT AND DIVERSIONARY SERVICES	OUTPATIENT SERVICES
	receiving facility, elapsed days will not be reimbursed or considered for appeal.	
Concurrent Review	See the Information Due at Time of Review Table	
Extended Stay Authorization	Continuation beyond the previously authorized length of stay requires review and approval by CHIPA prior to expiration of the existing authorization.	Upon request as part of the Quality Management program, a provider must submit requested medical records for review. The requested review information should be submitted within two weeks of the date of the request for review.
Notice of Authorization Determination	▪ Members must be notified of all pre-service and concurrent denial decisions. Members are notified by electronic notification of all acute pre-service and concurrent denial decisions. For members in inpatient settings, the denial letter is delivered electronically to the member on the day the adverse determination is made, prior to discharge. The service is continued without liability to the member until the member has been notified of the adverse determination. ▪ 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	▪ Providers can establish coverage for a new member by submitting a request for authorization via Beacon's eServices. ▪ Outpatient authorizations are posted on eServices, whether approved, modified or denied, within the decision time frame specified below. Providers receive an email message, alerting them that a determination has been made. ▪ CHIPA also faxes an authorization letter to the provider if requested. However, we strongly encourage providers to opt out of receiving paper notices and to rely on eServices instead; log on to eServices to opt out of receiving paper notices. ▪ Both electronic and paper notices specify the number of units (sessions) approved, the time frame within which the authorized visits may be used, and an explanation of any modifications made by CHIPA. ▪ Denials for extended outpatient services may be appealed by the

	INPATIENT AND DIVERSIONARY SERVICES	OUTPATIENT SERVICES
	on state and/or federal statutes, an explanation of the member's appeal rights and the appeals process is enclosed with all denial letters. ▪ Notice of inpatient authorization is mailed to the admitting facility.	member or provider and are subject to the reconsideration process.

UTILIZATION MANAGEMENT REVIEW REQUIREMENTS – INPATIENT AND DIVERSIONARY

PRE-SERVICE REVIEW	CONTINUED STAY (CONCURRENT) REVIEW	POST-SERVICE REVIEW
The facility clinician making the request needs the following information for a pre-service review: ▪ Member's health plan identification number ▪ Member's name, gender, date of birth, and city or town of residence ▪ Admitting facility name and date of admission ▪ Primary DSM/ICD diagnosis is required (A provisional diagnosis is acceptable.) ▪ Description of precipitating event and current symptoms requiring inpatient psychiatric care ▪ Medication history ▪ Substance use history ▪ Prior hospitalizations and psychiatric treatment ▪ Member's and family's general medical and social history	To conduct a continued stay review, call a utilization review clinician with the following required information: ▪ Member's current diagnosis and treatment plan, including physician's orders, special procedures, and medications ▪ Description of the member's response to treatment since the last concurrent review ▪ Member's current mental status, discharge plan, and discharge criteria, including actions taken to implement the discharge plan ▪ Report of any medical care beyond routine is required for coordination of benefits with health plan (Routine medical care is included in the per diem rate.)	Post-service reviews may be conducted for inpatient, diversionary or outpatient services rendered when necessary. To initiate a post-service review, call CHIPA. If the treatment rendered meets criteria for a post-service review, the UR clinician will request clinical information from the provider, including documentation of presenting symptoms and treatment plan via the member's medical record.CHIPA requires only those section(s) of the medical record needed to evaluate medical necessity and appropriateness of the admission, extension of stay, and the frequency or duration of service. A CHIPA physician or psychologist advisor completes a clinical review of all available information, in order to render a decision.

PRE-SERVICE REVIEW	CONTINUED STAY (CONCURRENT) REVIEW	POST-SERVICE REVIEW
▪ Recommended treatment plan relating to admitting symptoms and the member's anticipated response to treatment		

Authorization determination is based on the clinical information available at the time the care was provided to the member.

RETURN OF INADEQUATE OR INCOMPLETE TREATMENT REQUESTS

All requests must be original and specific to the dates of service requested, and tailored to the member's individual needs. CHIPA reserves the right to reject or return authorization requests that are incomplete, lacking in specificity, or incorrectly filled out. CHIPA will provide an explanation of action(s) that must be taken by the provider to resubmit the request.

NOTICE OF INPATIENT/DIVERSIONARY APPROVAL OR DENIAL

Verbal notification of approval is provided at the time of pre-service or continuing stay review. For an admission, the evaluator then locates a bed in a network facility and communicates CHIPA's approval to the admitting unit. Notice of admission or continued stay approval is mailed to the member or member's guardian and the requesting facility within the time frames specified later in this chapter.

If the clinical information available does not support the requested level of care, the UR clinician discusses alternative levels of care that match the member's presenting clinical symptomatology, with the requestor. If an alternative setting is agreed to by the requestor, the revised request is approved. If agreement cannot be reached between the UR clinician and the requestor, the UR clinician consults with a CHIPA psychiatrist or psychologist advisor. All denial decisions are made by a CHIPA physician or psychologist advisor. The UR clinician and/or CHIPA physician advisor offers the treating provider the opportunity to seek reconsideration.

All member notifications include instructions on how to access interpreter services, how to proceed if the notice requires translation or a copy in an alternate format, and toll-free telephone numbers for TDD/TTY capability, in established prevalent languages (Babbel Card).

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 document LOCC (accessible through eServices or by contacting providerinquiry@beaconhs.com) to determine whether the service meets medical necessity for continuing outpatient care.

5.6. Decision and Notification Timeframes

CHIPA is required by the state, federal government, NCQA and URAC 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.

	TYPE OF DECISION	DECISION TIMEFRAMES	VERBAL NOTIFICATION	WRITTEN NOTIFICATION
Pre-Service Review				
Initial Request for Urgent Behavioral Services	Urgent	Within 72 hours	Within 24 hours of making the decision, not to exceed 72 hours	Within 72 hours of the receipt of request
Initial Request for Non-Urgent Behavioral 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 Behavioral Health Services	Non-Urgent/ Standard	Within 5 business days	Within 24 hours of making the decision	Within 2 business days of making the decision
Continued Request for Urgent Behavioral Health Services	Urgent	Within 24 hours of receipt of request	Within 24 hours of receipt of request	Within 24 hours of receipt of request
Post-Service				
Request for Behavioral 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 Reconsideration 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 L.A. Care. Please contact L.A. Care Appeals department at 1.888.522.1298.

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

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 health plan members under any circumstances for covered services rendered, excluding co-payments 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 Health Strategies or L.A. Care receives the claim. L.A. Care will forward to Beacon, within 10 calendar days of receipt, all claims received by L.A. Care that are the financial responsibility of Beacon. The date that the claim is received at L.A. Care shall be used by Beacon as the date that the claim is received.

Claims for Inpatient Services

- The date range on an inpatient claim for an entire admission (i.e., not an interim bill) must include the admission date through the discharge date. The discharge date is not a covered day of service but must be included as the "to" date. Refer to authorization notification for correct date ranges.
- Beacon accepts claims for interim billing that include the last day to be paid as well as the correct bill type and discharge status code. On bill type X13, where X represents the "type of facility" variable, the last date of service included on the claim will be paid and is not considered the discharge day.
- Providers must obtain authorization from L.A. Care for all ancillary medical services provided while a plan member is hospitalized for a behavioral health condition. Such authorized medical services are billed directly to the health plan.
- Beacon's contracted reimbursement for inpatient procedures reflect all-inclusive per diem rates.

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. See 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.
- Claims for inpatient and institutional services must include the appropriate discharge status code. The following table lists HIPAA-compliant discharge status codes.

DISCHARGE STATUS CODES

CODE	DESCRIPTION
1	Discharged to Home/Self-Care
2	Discharged/Transferred to a Short-Term General Hospital for Inpatient Care
3	Discharged/Transferred to Skilled Nursing Facility
4	Discharged/Transferred to Intermediate Care Facility
5	Discharged/Transferred to a Designated Cancer Center or Children's Hospital
6	Discharged/Transferred to Home/Home Health Agency
7	Left Against Medical Advice or Discontinued Care
8	Discharged/Transferred Home/IV Therapy
9	Admitted as Inpatient to this Hospital
20	Expired
30	Still a Patient

* All UB04 claims must include the three-digit bill type codes according to the following table:

BILL TYPE CODES

TYPE OF FACILITY – 1ST DIGIT	BILL CLASSIFICATION – 2ND DIGIT	FREQUENCY – 3RD DIGIT
1. Hospital	1. Inpatient	1. Admission through discharge claim
1. Skilled Nursing Facility	2. Inpatient professional component	2. Interim – First claim
2. Home Health Care	3. Outpatient	3. Interim Continuing Claims
3. Christian Science Hospital	4. Diagnostic Services	4. Interim – Last Claim
5. Christian Science Extended Care Facility	5. Intermediate Care – Level I	5. Late Charge Only
6. Intermediate Care Facility	6. Intermediate Care – Level II	6-8. Not Valid

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
- Within 180 days of the date of discharge on inpatient claims

Providers are encouraged to submit claims as soon as possible for prompt adjudication. Claims submitted after the 180-day filing limit are subject to reduction in payment per Medi-Cal regulations or denial 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 and substance use 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 Dispute Resolution 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 L.A. Care 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; or
- 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); or
- 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; and
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 the provider's position on the dispute, and a patient's written registration for the provider to represent said patients.
4. Non-contracting providers are also required to submit a completed and signed Wavier of Liability Notice which is available on our website at www.beaconhealthstrategies.com.

All inquiries regarding the status of a provider dispute or about filing a provider dispute or other inquiries must be directed to Beacon's Provider Dispute Department at 1.877.344.2858, option 5.

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.beaconhealthstrategies.com, or a personalized form to submit the required information.

All provider disputes must be sent by either fax to 1.877.563.3480, by email to providerdisputes@beaconhs.com, or by mail to the attention of Provider Disputes at the following:

Beacon Health Options
P.O. Box 1864

Hicksville, NY 11802-1864

Non-contracting providers are also required to submit a completed and signed Wavier of Liability Notice which is available on our website at www.beaconhealthstrategies.com.

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 Clinician Dispute Resolution Request – Multiple like Claims Form or a personalized form with the required information.

TIME PERIOD FOR SUBMISSION OF PROVIDER DISPUTES

Provider disputes must be received by Beacon within 365 calendar days from Beacon's action that led to the dispute or the most recent action if there are multiple actions that led to the dispute, or in the case of inaction, provider disputes must be received by CHIPA within 365 calendar days after Beacon's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

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 (5) business 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.

7.5. Provider Education and Outreach

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 material 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
- EDI.Operations@beaconhs.com
- ProviderDisputes@beaconhs.com

Telephone

- Interactive Voice Recognition (IVR): 1.888.210.2018

  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: 1.877.344.2858

  Hours of operation are 8 a.m. to 6 p.m., Monday through Friday.

- Beacon's Main Telephone Numbers

Provider Relations	1.877.344.2858, option 6, then 3
EDI	1.877.344.2858
TTY	1.800.735.2929

ELECTRONIC MEDIA OPTIONS

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

- Electronic Data Interchange (EDI) supports electronic submission of claims 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; and
  - Beacon's L.A. Care plan-specific ID: 053
- 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

The table 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.

TRANSACTION	ACCESS ON			APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
	EDI	ESERVICES	IVR			
Member Eligibility Verification	Y	Y	Y	▪ Completing any claim transaction; ▪ 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 180 days after the date of service	N/A
Resubmission of Denied Claim	Y	Y	N	Previous claim was denied for any reason except timely filing	Within 180 days after the date of service	▪ Claims denied for late filing may be resubmitted as reconsiderations. ▪ Rec ID is required to indicate that 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 90-day filing limit, and must include evidence that one of the following conditions is met: ▪ Provider is eligible for	Within 180 days after the date of service	▪ Waiver requests will be considered only for these three circumstances. A waiver request that presents a reason not listed here, will result in a claim denial on a future EOB.

TRANSACTION	ACCESS ON			APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
	EDI	ESERVICES	IVR			
				reimbursement retroactively ▪ Member was enrolled in the 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.)		▪ A claim submitted beyond the filing limit that does not meet the above criteria may be submitted as a 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 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 nonpayment.	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	N/A	Do NOT send a refund check to Beacon

TRANSACTION	ACCESS ON			APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
	EDI	ESERVICES	IVR			
				amount to Beacon		
Request for Adjustment	Y	Y	N	▪ The amount paid to provider on a claim was incorrect ▪ Adjustment may be requested to correct: - underpay-ment (positive request); or - 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, re-payment of 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

TRANSACTION	ACCESS ON			APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
	EDI	ESERVICES	IVR			
						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 claims 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 claims 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:

Beacon Health Options
P.O. Box 1862
Hicksville, NY 11802-1862

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

Professional Services: Instructions for Completing the CMS 1500 Form

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.

The following table 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 BLOCK #	REQUIRED?	DESCRIPTION
1	No	Check Applicable Program
1a	Yes	Member's ID Number
2	Yes	Member's Name
3	Yes	Member's Birth Date and Sex
4	No	Insured's Name
5	Yes	Member's Address
6	No	Member's Relationship to Insured
7	No	Insured's Address
8	No	Member's Status
9	No	Other Insured's Name (if applicable)
9a	No	Other Insured's Policy or Group Number
9b	No	Other Insured's Date of Birth and Sex
9c	No	Employer's Name or School Name
9d	No	Insurance Plan Name or Program Name
10a-c	No	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	No	Member's or Authorized Person's Signature and Date on File

TABLE BLOCK #	REQUIRED?	DESCRIPTION
13	No	Member's Authorized 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	No	Additional Claim Information (Designated by NUCC), if applicable. (Record ID if applicable)
20	No	Outside Lab?
21	Yes	Diagnosis or Nature of Illness or Injury.
22	No	Medicaid Resubmission Code or Former Control Number
23	No	Prior Authorization Number (if applicable)
24a	Yes	Date of Service
24b	Yes	Place of Service Code (HIPAA-compliant)
24d	Yes	Procedure Code and Modifier, when applicable
24e	Yes	Diagnosis Code 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

TABLE BLOCK #	REQUIRED?	DESCRIPTION
27	No	Accept Assignment (check box)
28	Yes	Total Charges
29	No	Amount Paid by Other Insurance (if applicable)
30	No	Balance Due
31	Yes	Signature of Physician/Practitioner
32	Yes	Name and Address of Facility where services were rendered (Site ID). If missing, a claim specialist will choose 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

Institutional Services: Instructions for Completing the UB04 Form

The following table lists each numbered block on the UB04 claim form, with a description of the requested information and whether that information is required in order for a claim to process and pay.

TABLE BLOCK #	REQUIRED?	DESCRIPTION
1	Yes	Provider Name, Address, Telephone #
2	No	Untitled
3	No	Provider's Member Account Number
4	Yes	Type of Bill (3-digit codes)
5	Yes	Federal Tax ID Number
6	Yes	Statement Covers Period (include date of discharge)
7	No	Covered Days (do not include date of discharge)
8	Yes	Member Name
9	Yes	Member Address

TABLE BLOCK #	REQUIRED?	DESCRIPTION
10	Yes	Member Birthdate
11	Yes	Member Sex
12	Yes	Admission date
13	Yes	Admission Hour
14	Yes	Admission Type
15	Yes	Admission Source
16	Yes	Discharge Hour
17	Yes	Discharge Status
18-28	No	Condition Codes
29	No	ACDT States
30	No	Unassigned
31-34	No	Occurrence Code and Date
35-36	No	Occurrence Span
37	No	Untitled
38	No	Untitled
39-41	No	Value CD/AMT
42	Yes	Revenue Code (if applicable)
43	Yes	Revenue Description
44	Yes	Procedure Code (CPT) (Modifier may be placed here beside the HCPCS code)
45	Yes	Service Date
46	Yes	Units of Service
47	Yes	Total Charges
48	No	Non-Covered Charges

TABLE BLOCK #	REQUIRED?	DESCRIPTION
49	Yes	Modifier (if applicable)
50	No	Payer Name
51	Yes	Beacon Provider ID Number
52	Yes	Release of Information Authorization Indicator
53	Yes	Assignment of Benefits Authorization Indicator
54	Yes	Prior Payments (if applicable)
55	No	Estimated Amount Due
56	Yes	Facility NPI
57	No	Other ID
58	No	Insured's Name
59	No	Member's Relationship to Insured
60	Yes	Member's Identification Number
61	No	Group Name
62	No	Insurance Group Number
63	Yes	Prior Authorization Number (if applicable)
64	No	RecID Number for Resubmitting a Claim
65	No	Employer Name
66	No	Employer Location
67	Yes	Principal Diagnosis Code
68	No	A-Q Other Diagnosis
69	Yes	Admit Diagnosis
70	No	Patient Reason Diagnosis
71	No	PPS Code

TABLE BLOCK #	REQUIRED?	DESCRIPTION
72	No	ECI
73	No	Unassigned
74	No	Principal Procedure
75	No	Unassigned
76	Yes	Attending Physician NPI/TPI – First and Last Name and NPI
77	No	Operating Physician NPI/TPT
78-79	No	Other NPI
80	No	Remarks
81	No	Code-Code

Paper Resubmission

See earlier table for an explanation of claims 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; or
- 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 earlier table 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:

  Beacon Health Options

  P.O. Box 1862

  Hicksville, NY 11802-1862

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. **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 earlier table 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: College Health IPA/Beacon Claims Department

  Beacon Health Options

  P.O. Box 1862

  Hicksville, NY 11802-1862

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 identification 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

Medi-Cal Expansion Addendum

BEHAVIORAL HEALTH BENEFITS

L.A. Care 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, and delivered by contracted network providers.

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)
96136	Psychological testing (first 30 min)

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 for 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 a claims-based algorithm to monitor utilization.

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

L.A. CARE BEHAVIORAL HEALTH BENEFITS

- Beneficiaries should undergo screening with Beacon clinician prior to receiving outpatient services.
- It is the 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.
- Substance use disorder treatment is not provided through the managed care plan benefit. Beneficiaries in need of substance use disorder treatment will be given referrals for services.
- 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.

Screening Requirements

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.

Screening can be completed by a Beacon clinician at the time of service request, or the screening tool can be submitted by network providers for review and registration of services. 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.

Authorization Grid

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)	
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)	
96136	Psychological testing (first 30 min)	
96116	Neurobehavioral status exam (first hour)	
96121	Neurobehavioral status exam (additional hour)	

Cal MediConnect Addendum

The federal Centers for Medicare and Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) have developed a voluntary, three-year program designed to coordinate medical, mental and substance use disorder care, long-term care, and home- and community-based services under one plan for people eligible for both Medicare and Medi-Cal ("Duals" or "Dual Eligibles").

The Cal MediConnect Health Plan is open to certain Dual Eligible beneficiaries who have been con- firmed as eligible for both Medicare and Medi-Cal benefits by CMS as well as the state of California's Department of Health Care Services. Enrolling members must meet all of the applicable eligibility requirements for membership and have voluntarily elected to enroll in the Cal MediConnect program.

Certain beneficiaries who are confirmed as Dual Eligible by CMS and DHCS are excluded from participation in the Cal MediConnect program. Per DHCS, these participant populations excluded from enrollment in Cal MediConnect include, but are not limited to:

- Beneficiaries under age 21
- Beneficiaries in rural zip codes excluded from managed care
- Beneficiaries who are residents of Intermediate Care Facilities for the developmentally disabled

For a detailed chart outlining the Cal MediConnect participating populations, please go to the Coordinated Care Initiative section of the DHCS website and review the CCI Population Chart.

Cal MediConnect provides comprehensive, coordinated medical services to members on a prepaid basis through an established provider network. Cal MediConnect members must choose a primary care provider and have all their care coordinated through this physician-provider.

CAL MEDICONNECT COVERED BENEFITS

Under the Cal MediConnect program, all Medicare and non-specialty Medi-Cal mental health services are the responsibility of the Cal MediConnect plan and included in its capitation payment for the Demonstration Project. Medi-Cal specialty mental health services not covered by Medicare benefits will not be included in the Cal MediConnect plan's capitation payment. The Cal MediConnect plan and the Local Mental Health Plan (LMHP) will collaborate to ensure enrollees have access to coordinated Medi- care and Medi-Cal services. Medi-Cal specialty mental health services will continue to be the financial responsibility of the LMHP for beneficiaries who meet medical necessity criteria for those services.

Covered benefits include:

- Medicare Part A services
- Medicare Part B services
- Medicare Part D – prescription drugs
- Medi-Cal skilled nursing care + LTSS (IHSS, MSSP, CBAS)
- Non-emergency medical transportation
- Dental care
- Vision care
- Medi-Cal specialty mental health and drug Medi-Cal services are not included, as shown below

Division of Behavioral Health Benefits in Cal MediConnect

CAL MEDICONNECT BENEFITS	MEDI-CAL "CARVED OUT" BENEFITS
▪ Inpatient Psychiatric Care ▪ Psychiatric Testing/Assessment ▪ Medication Management ▪ Therapy (Group and Individual) ▪ Partial Hospitalization Program and Intensive Outpatient Program (IOP) ▪ Alcohol and/or Drug Outpatient Services ▪ Detoxification ▪ Opioid Therapy ▪ Pharmacy (Medicare Part D)	▪ Mental Health Services (Rehabilitation and Care Plan Development) ▪ Day Treatment Intensive and Day Rehab ▪ Crisis Intervention and Crisis Stabilization ▪ Adult Residential Treatment ▪ Crisis Residential Treatment ▪ Targeted Case Management ▪ Methadone Maintenance Therapy ▪ Day Care Rehabilitation ▪ Residential Drug and Alcohol Services

CAL MEDICONNECT MODEL OF CARE

The Cal MediConnect model of care is designed to be person-centered and help improve access to medical, behavioral health and social services. This model allows members access to affordable care and preventive health services at the right time and in the member's preferred setting.

Care Coordination

The Cal MediConnect program will provide a proactive and comprehensive system of care for en- rolled individuals living with chronic physical diseases, mental illness, substance use disorders and/or developmental and intellectual disabilities that promotes person-centered, integrated care across the spectrum of medical, behavioral, psycho-social and long-term services and supports. This approach is aimed at eliminating fragmented and often poorly coordinated healthcare and social services that historically plague the effective treatment for these individuals and results in poor health status and ineffectual expenditures. Each member is assigned a care manager or care coordinator.

Some members with complex needs may require an ICT, and any member who requests an Interdisciplinary Care Team (ICT) will receive one. The care manager leads the member's ICT and links closely to the member's PCP to support him/her in ensuring the member gets the care needed across the full spectrum of medical, behavioral health and long-term care services.

The Cal MediConnect plans use predictive modeling, based on claims history and analytics to deter- mine each member's risk level and level of intervention required to channel the member to the required level of coordination.

The member is encouraged to participate in all aspects of care management and coordination, including in the development of an Individualized Care Plan (ICP). The care coordinator and ICT ensure that the member receives any necessary assistance and accommodation, including those mandated by the ADA, to prepare for and fully participate in, the care planning process.

The team, furthermore, ensures that the member receives clear information about:

- His or her health conditions and functional limitations

- How family members and social supports can be involved in the care planning as the member chooses
- Self-directed care options and assistance available to self-manage care
- Opportunities for educational and vocational activities
- Available treatment options, supports and/or alternative courses of care
- Ways to participate in developing his/her own care plan

Provider participation includes:

1. Interdisciplinary Care Team (ICT), member care conferences via phone, through exchange of written communications and possibly in person
2. Inbound and outbound communications to support care coordination
3. Promotion of Healthcare Effectiveness Data and Information Set (HEDIS®) and National Committee for Quality Assurance (NCQA) quality measures
4. Forwarding all medical record documentation and information as requested to support the Cal MediConnect plans' fulfillment of state and federal regulatory and accreditation obligations, e.g., HEDIS and NCQA

Provider's role and responsibility in care coordination, care transitions, comprehensive medication reviews and preventive screenings include the following:

1. Ensure that members are informed of specific healthcare needs requiring follow-up and that members receive training in self-care, including medication adherence and other measures they may take to promote their own health
2. Ensure the member receives appropriate specialty, ancillary, emergency and hospital care when needed, and provide necessary referrals, member information and communications to specialists, hospitalists, skilled nursing facilities (SNF) and other providers to assist with consultation, as well as recommending treatments, equipment and/or services for the member
3. Provide coordination of care for members who are homebound or have significant mobility limitations to ensure access to care through home visits by nurse practitioners or physicians
4. Track and document appointments, clinical findings, treatment plans and care received by members referred to specialists, other healthcare providers or agencies to ensure continuity of care
5. Obtain authorizations and notify Beacon for any out-of-network services when a network provider of the specialty in question is not available in the geographical area
6. Work with the Cal MediConnect plans' care coordination teams to arrange for a member to receive a second opinion, when the member requests one, from a qualified network healthcare professional or arrange for the member to obtain one outside the network if a qualified network provider is not available
7. Initiate or assist with the discharge or transfer of members from an inpatient facility to the most medically appropriate level of care facility or back to the member's home or permanent place of domicile; consider the availability of in-network facilities and obtain appropriate authorizations if using out-of-network facilities

Provider communication and reporting expectations include the following:

1. Maintain frequent communication, in person or by phone, with the ICT, including other providers of care and services, such as specialists, hospitals and/or ancillary providers to ensure continuity of care and effective care coordination
2. Immediately report actual or suspected abuse, domestic violence or exploitation to the local law enforcement agency by telephone and submit a follow-up written report to the local law enforcement agency within the time frames as required by law
3. Provide timely access to medical records or information for quality management and other purposes, including audits, reviews of complaints or appeals, HEDIS and other studies, and promptly respond to recommendations for improvement by developing and enacting a corrective/improvement plan, as appropriate
4. Follow the preventive care guidelines set by the U.S. Preventive Services Task Force, and provide and document the preventive care services required by the NCQA for HEDIS Quality Assurance Reporting requirements

Interdisciplinary Care Team

The Interdisciplinary Care Team (ICT) is a team of caregivers from different professional disciplines who work together to deliver care services focused on care planning to optimize quality of life and to support the individual and/or family.

The Interdisciplinary Care Team model supports many facets of care, such as:

- Member education and connections to community resources
- Reinforcement of provider treatment and medication plan
- Provider practice goals
- Preventive screenings and wellness support
- Care coordination and care transitions
- Appropriate advanced illness and end-of-life planning

The ICT may include:

- The member and/or his/her authorized caregiver
- The member's physicians and/or nurses
- Health plan/Beacon clinical care managers and coordinators
- Social workers and community social-service providers
- The member's behavioral health professionals
- Health plan community health educators and resource-directory specialists

Considerations for members with special needs include the following:

1. Providers must make efforts to understand the special needs required by members. The member may have challenges that include physical compromises as well as cognitive, behavioral, social and financial issues. Multiple comorbidities, complex conditions, frailty, disability, end-of-life issues, end-stage renal disease, isolation, depression and polypharmacy are some of the challenges facing these members each day, in addition to cultural, language, and transportation barriers.

2. Recognizing the significant needs of members, Cal MediConnect plans incorporate all of the principles of multidisciplinary integration, as well as person-centered care planning, coordination and treatment in our care coordination program.
3. Integrated care management is delivered within an ICT structure and holistically addresses the needs of each member.
4. The member and/or his/her authorized caregiver are maintained at the core of the model of care ensuring person-centered care and supported self-care.

DETERMINATION OF ELIGIBILITY FOR SPECIALTY MENTAL HEALTH SERVICES

The criteria for provision of specialty mental health services are set forth in Title 9, California Code of Regulations (CCR) sections 1820.205, 1830.205, 1830.210. Criteria for Medi-Cal specialty mental health services include, but are not limited to:

- One or more of the disorders identified in the Diagnostic and Statistical Manual of Mental Disorders, currently used by DHCS to determine Medi-Cal medical necessity, excepting those disorders specifically excluded by regulation
- Specific impairments as a result of the mental disorder or probability of deterioration of an important area(s) of life functioning
- Services that must address the impairment, be expected to significantly improve the condition, and the condition is not responsive to physical health care based treatment
- Services must be best delivered in a specialty mental health setting

Required Cal MediConnect Training

Beacon provides training and makes materials available online for behavioral health providers and potential members of the Interdisciplinary Care Team (ICT). Cal MediConnect contracted providers are required to complete this training at time of contracting, for any newly hired staff, on the following:

- Cal MediConnect plan/Beacon model of care and operations
- The person-centered planning processes
- Linguistic and cultural competency
- Accessibility and accommodations
- Provider communications
- Claims submission and payment
- Fraud, waste and abuse
- Mandatory reporting requirements for health and safety

Please have staff review the training materials and complete the attestation online. Auditing of required training curricula, including training materials, dates of training sessions and signed attestations of completion, will be included in annual oversight auditing processes.

Providers can access the entire training library as well complete the training attestation form online by following these instructions:

1. Go to: https://www.coursesites.com/s/_CMCduals

2. Click **Self-Enroll**.
    i. ***Result:*** The access code dialog box appears.
3. Type **dualscalifornia** for the course access code:
    i. Click **Save and Continue**.
    ii. ***Result:*** The Cal MediConnect – CA Duals Provider Training page appears.
4. Click **I Need a CourseSites Account**.
    i. ***Result:*** The Create New Student Account page appears.
5. Complete the **Create New Student Account** page:
    i. Click **Save and Continue**.
    ii. ***Result:*** The "Hello" pop-up dialog box appears.
6. Click **Go to Course**.
    i. ***Result:*** A "Welcome to the new Blackboard" screen appears over the course Home Page.
7. Click **I'll do it later**.
    i. ***Result:*** The course Home Page appears.

DEFINITIONS OF INTERAGENCY TEAMS

To ensure that Medicare and Medi-Cal services are coordinated into a seamless system of care, the Cal MediConnect Plans, Local Mental Health Plan (LMHP) and Substance Abuse Prevention Council (SAPC), shall establish three interagency care management teams for behavioral health composed of, but not limited to, representatives from each of the entities. The interagency care management teams are responsible, as described below, for ensuring that health, mental health, substance use and LTSS services are easily accessible and coordinated for beneficiaries, including beneficiaries receiving Medicare behavioral health services through Cal MediConnect.

1. **Program Administration Team (PAT)** has the following shared responsibilities:
    - Develop algorithms, and policies and procedures to assist the BHCMT in its day-to-day operations
    - Identify systemic and programmatic issues and provide recommendations for resolution of problem areas
    - Conduct program evaluation
    - Resolve disputes between Cal MediConnect Plan, the LMHP, and SAPC
    - Identify and resolve provider relations issues
2. **Behavioral Health Care Management Team (BHCMT)** is a multidisciplinary team that provides care management and care coordination for Medicare and Medi-Cal services, and authorization for Medicare services to beneficiaries enrolled in the Demonstration Project. The BHCMT is composed of representatives from the health plan, health plan's delegated behavioral health entity, LMHP, and SAPC. Led by the health plan, BHCMT has the following responsibilities:
    - Authorize covered behavioral health services for certain delegated health plans based upon algorithms developed by the PAT. Develop individual behavioral health care plans.

- Coordinate care between physical health, mental health and substance use providers
- Monitor individual clinical progress
- Reassess individual service needs
- Refer and link to appropriate services
- Serve as the liaison to the ICT for beneficiaries who also need non-behavioral health services
- Resolve disputes between Cal MediConnect Plan, LMHP, and SAPC

3. **Interdisciplinary Care Team (ICT)** is a team composed of physical health, behavioral health, and social service providers that collectively manages the medical, cognitive, psychosocial and functional services of beneficiaries. The ICT also includes a representative from the BHCMT.

REFERRAL PROCESS FOR BEHAVIORAL HEALTH SERVICES

1. The Dual Eligible Demonstration Project shall have a “no wrong door” approach to service access, with multiple entry paths for Beneficiaries to access behavioral health services. Referrals may come from various sources including, but not limited to, beneficiary self-referrals.
2. All incoming referrals or requests for behavioral health services shall be screened and triaged according to procedures established by the BHCMT to determine behavioral health need, and to refer and link beneficiaries to a behavioral health provider and/or to SAPC for substance use disorders treatment and recovery services.