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 /

Serving the County of Orange Health Care Agency

This document contains chapters 1-7 of Beacon's Behavioral Health Policy and Procedure Manual for providers serving Orange County Health Care Agency members. The materials referenced within this manual are available on Beacon's website. Chapters that contain all level of care service descriptions and criteria will be posted on eServices. To obtain a copy, please email provider.inquiry@beaconhealthoptions.com.

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Chapter 1

Introduction

1.1. About this Provider Manual

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

The Manual serves as an administrative guide outlining Beacon's policies and procedures governing network participation, service provision, claims submission, quality management and improvement requirements, in Chapters 1-4. Detailed information regarding clinical processes, including authorizations, utilization review, reconsiderations and appeals are found in Chapters 5 and 6. Chapter 7 covers billing transactions and Beacon's level of care criteria are presented in Chapter 8, accessible only through eServices or by calling Beacon. Additional information is provided in the following appendix:

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

The Manual is posted on Beacon's website, www.beaconhealthoptions.com and on Beacon's eServices; only the version on eServices includes Beacon's level of care criteria. Providers may request a printed copy of the Manual by calling Beacon at 800.723.8641. Updates to the Manual as permitted by the PSA are posted on Beacon's website, and notification may also be sent by postal mail and/or email. Beacon provides notification to network providers at least 60 days prior to the effective date of any policy or procedural change that impacts providers, such as modification in payment or covered services. Beacon provides 60 days' notice unless the change is mandated sooner by state or federal requirements.

1.2. Introduction Orange County Health Care Agency

The Orange County Health Care Agency (OCHCA) is the Local Mental Health Plan for Specialty Mental Health Services in Orange County. Mental and behavioral health services are a covered benefit for Orange County Medi-Cal members. Depending on the medically necessary level of care, Orange County Medi-Cal members receive their Specialty Mental Health Services directly from OCHCA or Beacon

1.3. Orange County Mental Health Plan Behavioral Health Program

The Orange County Mental Health Plan provides members with access to Specialty Mental Health Services, in part through Beacon's 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.

As of July 1, 2015, the Orange County Health Care Agency Plan has contracted with Beacon to administer the provision of certain mental and behavioral health services. Beacon specializes in managed behavioral health care for Medi-Cal recipients with a focus on the integration of behavioral and physical health services.

1.4. Introduction to Beacon

Beacon Health Strategies LLC (Beacon), a Beacon Health Options company, is a limited liability, managed behavioral health company. 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, the Beacon Health Options family of companies serves more than 48 million individuals on behalf of more than 350 client organizations across the country and in the UK. 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. Additional Information

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

1. Go to the Provider Tools page of the Beacon website for detailed information about working with Beacon, frequently asked questions, clinical articles and practice guidelines, and links to additional resources.
2. Call Interactive Voice Recognition (IVR), 888.210.2018, to check member eligibility, number of visits available and applicable co-payments, confirm authorization, and get claims status.
3. Log on to eServices to check member eligibility and number of visits available, submit claims and authorization requests, view claims and authorization status, view/print claim reports, update practice information, and use other electronic tools for communication and transactions with Beacon.
4. Email provider.inquiry@beaconhealthoptions.com.
5. Go to Beacon's website for other Beacon contact information.
6. To check the eligibility status of Medi-Cal beneficiaries, you can use the DHS online eligibility verification system at https://www.medi-cal.ca.gov/eligibility/login.asp.

Chapter 2

Provider Participation in Beacon's Behavioral Health Services Network

2.1. Network Operations

Beacon's Network Operations Department, with Provider Relations, is responsible for procurement and administrative management of Beacon's behavioral health provider network. As such, their role includes contracting, credentialing, and provider relations functions. Representatives are easily reached 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 Beacon and has signed a Provider Services Agreement (PSA) with Beacon. Participating providers agree to provide mental health services to members, to accept reimbursement directly from Beacon according to the rates set forth in the fee schedule attached to each provider's PSA, and to adhere to all other terms in the PSA including this provider manual.

Participating providers who maintain approved credentialing status remain active network participants unless the PSA is terminated in accordance with the terms and conditions set forth therein. In cases where a provider is terminated, they may notify the member of their termination, but in all cases Beacon will always notify members when their provider has been terminated.

2.3. Transactions and Communication with Beacon

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

ELECTRONIC MEDIA

Beacon's website is the primary information source for behavioral health providers. You will find news and updates, answers to frequently asked questions, clinical information and resources, claims/billing information, and companion guides. Providers should use the provider search tool to be sure their practice information, available to members, is current. If not, please edit and update your record in eServices.

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. eServices is completely free to contracted providers and is accessible 24 hours a day, seven days a week through www.beaconhealthoptions.com.

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

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

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

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

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

2. Interactive Voice Recognition

Interactive voice recognition (IVR) is available to providers as an alternative to eServices. It provides accurate, up-to-date information by telephone and is available for selected transactions at 888.210.2018.

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

3. Electronic Data Interchange

Electronic data interchange (EDI) is available for claims submission and eligibility verification directly by the provider to Beacon or via an intermediary. For information about testing and setup for EDI, please go to www.beaconhealthoptions.com and download Beacon's 837 & 835 companion guides.

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

For technical and business-related questions, email edi.operations@beaconhealthoptions.com. To submit EDI claims through an intermediary, contact the intermediary for assistance. If using Emdeon, use Beacon's Emdeon Payer ID and Beacon's Health Plan ID is 158.

TABLE 2-1: ELECTRONIC TRANSACTIONS AVAILABILITY

TRANSACTION/CAPABILITY	AVAILABLE 24/7		
	ESERVICES	IVR	EDI
Verify member eligibility, benefits, and co-payments	Yes	Yes	Yes (HIPAA 270/271)
Check number of visits available	Yes	Yes	Yes (HIPAA 270/271)
Submit outpatient authorization requests	Yes	N/A	N/A

TRANSACTION/CAPABILITY	AVAILABLE 24/7		
	ESERVICES	IVR	EDI
View authorization status	Yes	Yes	N/A
Update practice information	Yes	N/A	N/A
Submit claims	Yes	N/A	Yes (HIPAA 837)
Upload EDI claims to Beacon and view EDI upload history	Yes	N/A	Yes (HIPAA 837)
View claim status and print EOBs	Yes	Yes	Yes (HIPAA 835)
Print claims reports and graphs	Yes	N/A	N/A
Download electronic remittance advice	Yes	N/A	Yes (HIPAA 835)
EDI acknowledgment and submission reports	Yes	N/A	Yes (HIPAA 835)
Pend authorization requests for internal approval	Yes	No	No
Access CHIPA's level of care criteria and provider manual	Yes	No	No

EMAIL

Beacon encourages providers to communicate via email addressed to provider.inquiry@beaconhealthoptions.com using your resident email program or internet mail application.

Throughout the year, Beacon sends provider alerts related to regulatory requirements, protocol changes, helpful reminders regarding claim submission, etc. In order to receive these notices in the most efficient manner, we strongly encourage you to enter and update email addresses and other key contact information for your practice through eServices.

COMMUNICATION OF MEMBER INFORMATION

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

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

2.4. Access Standards

TABLE 2-2: APPOINTMENT STANDARDS AND AFTER HOURS ACCESSIBILITY

TYPE OF APPOINTMENT/SERVICE	APPOINTMENT ACCESS TIME FRAMES AND EXPECTATIONS
General Appointment Standards	
Routine/Non-Urgent Services	Within 14 calendar days
Urgent Care	Within 24 hours
Emergency Services	Immediately; 24 hours a day, seven days per week
After Hours Service Availability	
On-Call	▪ 24-hour on-call services for all members in treatment ▪ Ensure that all members in treatment are aware of how to contact the treating or covering provider after hours and during provider vacations
Crisis Intervention	▪ Services must be available 24 hours per day, 7 days per week. ▪ Outpatient facilities, physicians, and practitioners are expected to provide these services during operating hours. ▪ After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician, agency-affiliated staff, crisis team, or hospital emergency room.
Outpatient Services	▪ Outpatient providers should have services available Monday through Friday from 9 a.m. to 5 p.m., at a minimum ▪ Evening and/or weekend hours should also be available at least two days per week
Interpreter Services	▪ Under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency. Contact Beacon for assistance with this by calling 800.723.8641.

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

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

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

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

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

TABLE 2-3: REQUIRED NOTIFICATIONS

TYPE OF INFORMATION	METHOD OF NOTIFICATION	
	ESERVICES	EMAIL
General Practice Information		
Change in address or telephone number of any service	Yes	Yes
Addition or departure of any professional staff	Yes	Yes
Change in linguistic capability, specialty, or program	Yes	Yes
Discontinuation of any covered service listed in Exhibit A of the provider's PSA	Yes	Yes
Change in licensure or accreditation of provider or any of its professional staff	Yes (license)	Yes
Appointment Access		

TYPE OF INFORMATION	METHOD OF NOTIFICATION	
	ESERVICES	EMAIL
Change in hours of operation	Yes	Yes
No longer accepting new patients	Yes	Yes
Available during limited hours or only in certain settings	Yes	Yes
Restrictions on treating members (i.e., age range, etc.)	Yes	Yes
Temporarily or permanently unable to meet Beacon standards for appointment access	Yes	Yes
Other		
Change in designated account administrator for the provider's eServices accounts	No*	Yes
Merger, change in ownership, or change of tax identification number (As specified in the PSA, Beacon is not required to accept assignment of the PSA to another entity.)	No*	Yes
Adding a site, service or program not previously included in the PSA, remember to specify: a. Location b. Capabilities of the new site, service, or program	No*	Yes

Note that eServices capabilities are expected to expand over time, so that these and other changes may become available for updating in eServices. Providers may also notify Beacon of changes by phone.

2.7. Adding Sites, Services, and Programs

The PSA is specific to the sites and services for which the provider originally contracted with Beacon. A separate fee schedule is included in the PSA for each contracted site.

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 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.

Additionally, the provider shall:

- Maintain a safe facility
- If applicable, store and dispense medications according to state and federal standards
- Maintain client records that meet stated and federal standards
- Have an NPI number prior to performance any services under this agreement

2.8. Provider Credentialing and Recredentialing

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

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

TABLE 2-4: CREDENTIALING PROCESSES

INDIVIDUAL PRACTITIONER CREDENTIALING	ORGANIZATIONAL CREDENTIALING
Beacon individually credentials and recredentials the following categories of clinicians in private solo or group practice settings: ▪ Psychiatrists ▪ Psychologists ▪ Licensed Clinical Social Workers ▪ Master's level Clinical Nurse Specialists/ Psychiatric Nurses ▪ Licensed Mental Health Counselors ▪ Licensed Marriage and Family Therapists ▪ 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

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 notify the practitioner or the practice's credentialing contact of the date on which he or she may begin to serve members of specified plans.

ORGANIZATIONAL CREDENTIALING

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

The credentialed facility is responsible for credentialing and overseeing its clinical staff as Beacon does not individually credential facility-based staff. Master's level mental 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 mental 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
- Supervised in the provision of services by a licensed independent clinical social worker, a licensed psychologist, a licensed master's level clinical nurse specialist, or licensed psychiatrist meeting the contractor's credentialing requirements
- Absence of Medicare/Medicaid sanctions

Once the facility has been approved for credentialing and contracted with Beacon to serve members of one or more Plans, all licensed or certified behavioral health professionals listed may treat members in the facility 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. Prohibition on Billing Members

Members may not be billed for any covered service or any balance after reimbursement by Beacon except for applicable co-payments.

Further, providers may not charge the member 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.

Chapter 3

Members, Benefits, and Member-Related Policies

3.1. Mental Health Benefits

The Orange County Mental Health Plan offers benefit programs for Specialty Mental Health Services to eligible Orange County Medi-Cal enrollees. Under the plan, the following levels of care may be covered, based on eligibility and provided that services are medically necessary, delivered by contracted network providers, and that the authorization procedures in Chapter 5 are followed:

- Specialty Mental Health Services, as defined in Section 1810.247 of the Title IX California Code of Regulations
- Outpatient Mental Health Services
- Medication Support Services
- Psychotherapy Services

3.2. Outpatient Benefits

ACCESS

Outpatient behavioral health treatment is an essential component of a comprehensive health care delivery system. Orange County Medi-Cal beneficiaries may access Specialty Mental Health Outpatient Services by calling the Orange County Mental Health Plan access line at 800.723.8641 (TTY line is 866.727.9441). **All services require prior authorization.**

ADDITIONAL BENEFIT INFORMATION

- Benefits do not include payment for behavioral health services that are not medically necessary.
- Beacon, nor the Orange County Mental Health Plan, are 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 necessarily for the enrollee's care.
- Authorization is required for all services except emergency services.*

* See Chapter 5 for authorization procedures.

3.3. Member Rights and Responsibilities

MEMBER RIGHTS

The Plan and Beacon are firmly committed to ensuring that members are active and informed participants in the planning and treatment phases of their Specialty Mental Health Services. We believe that members become empowered through ongoing collaboration with their health care providers, and that collaboration among providers is also crucial to achieving positive health care outcomes.

Members must be fully informed of their rights to access treatment and to participate in all aspects of treatment planning. All plan beneficiaries have the following rights:

Right to Receive Information

Members have the right to receive information about Beacon's services, benefits, practitioners, their own rights and responsibilities, as well as the clinical guidelines. Members have a right to receive this information in a manner and format that is understandable and appropriate to the member's needs.

Right to Respect and Privacy

Members have the right to respectful treatment as individuals regardless of race, gender, gender identity, veteran status, religion, marital status, national origin, physical disabilities, mental disabilities, age, sexual orientation, or ancestry.

Right to Confidentiality

Members have the right to have all communication regarding their health information kept confidential by Beacon staff and all contracted providers, to the extent required by law.

Right to Participate in the Treatment Process

Members and their family members have the right to be offered and actively participate in treatment planning and decision making. The behavioral health provider will provide the member, or legal guardian, with complete current information concerning a diagnosis, treatment and prognosis in terms the member, or legal guardian, can be expected to understand. All members have the right to review and give informed consent for treatment, termination, and aftercare plans. Treatment planning discussions may include all appropriate and medically necessary treatment options, regardless of benefit design and/or cost implications.

Right to Treatment and Informed Consent

Members have the right to give or refuse consent for treatment and for communication with PCPs, specialists and other behavioral health providers. However, the benefits of this collaborative communication should be explained to the member and encouraged for the benefit of the member's overall care.

Right to Clinical/Treatment Information

Members and their legal guardian have the right to, upon submission of a written request; review the member's medical records. Members and their legal guardian may discuss the information with the designated responsible party at the provider site.

Right to Appeal Decisions Made by Beacon

Members and their legal guardian have the right to appeal Beacon's decision not to authorize care at the requested level of care, or Beacon'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 mental health provider appeal on their behalf according to the same procedures.

Right to Submit a Complaint or Grievance to Beacon

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

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

- The Beacon utilization review process
- The Beacon network of services

The procedure for filing a complaint or grievance is described in Chapter 4.

Please note: A member must exhaust the Plan grievance system before filing a State Fair Hearing. A State Fair Hearing must be requested within 120 days of a Plan's determination. (DHCS Mega-Rule: Requirement 27).

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 781.994.7642 or by TTY at 866.727.9441.

Right to Make Recommendations about Member Rights and Responsibilities

Members have the right to make recommendations directly to Beacon regarding Beacon's Member's Rights and Responsibilities statement. Members should direct all recommendations and comments to Beacon's Ombudsperson. All recommendations will be presented to the appropriate Beacon review committee. The committee will recommend changes to the policies as needed and as appropriate.

MEMBER RESPONSIBILITIES

Members of health plan agree to do the following:

- Choose a PCP and site for the coordination of all medical care. Members may change PCPs at any time by contacting their health plan.
- Carry the health plan identification card and show the card whenever treatment is sought.
- In an emergency, seek care at the nearest medical facility and call their PCP within 48 hours. The back of the health plan identification card highlights the emergency procedures.
- Provide clinical information needed for treatment to their behavioral health care provider.
- To the extent possible, understand their behavioral health problems and participate in the process of developing mutually agreed-upon treatment goals.
- Follow the treatment plans and instructions for care as mutually developed and agreed-upon with their practitioners.

POSTING MEMBER RIGHTS OR RESPONSIBILITIES

All contracted providers must display in a highly visible and prominent place, a statement of member's 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 one of the statements listed below, based on facility licensure. When posting is not possible, members should be provided with copy of their rights and responsibilities which should be documented in the member's clinical record.

- **California Department of Public Health (CDPH) licensed facilities**—Network facilities whose licenses are issued by CDPH are required to post CDPH's statement of human rights within the facility prominently, consistent with the primary language of the facility's membership.

- **All other network facilities**—Facilities not licensed by CDPH must visibly post a statement approved by their Board of Directors incorporating CDPH's statement of human rights. All hospitals that provide behavioral health inpatient services must have a human rights protocol that is consistent with California DMH requirements including a human rights officer and human rights committee.

INFORMING MEMBERS OF THEIR RIGHTS AND RESPONSIBILITIES

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

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

3.4. Non-Discrimination Policy and Regulations

In signing the Beacon PSA, providers agree to treat Plan members without discrimination. Providers may not refuse to accept and treat a 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 provider does not have the capability or capacity to provide appropriate services to a member, 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 specialty mental health care that is accessible, respectful, and maintains the dignity of the member.

3.5. Confidentiality of Member Information

All providers are expected to comply with federal, state, and local laws regarding access to member information. With the enactment of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), members give consent for the release of information regarding treatment, payment and

healthcare operations at the sign-up for health insurance. Treatment, payment, and healthcare operations involve various activities, including, but not limited to:

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

MEMBER CONSENT

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

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

CONFIDENTIALITY OF MEMBERS' HIV-RELATED INFORMATION

Beacon works 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 plan medical and disease management programs and accepts referrals for behavioral health case management from the 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 plan. Beacon will assist behavioral health providers or members interested in obtaining any of this information by referring them to plan's case 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 case management protocols require Beacon to provide any plan member with assessment and referral to an appropriate treatment source. It is Beacon's policy to follow federal and state information laws and guidelines concerning the confidentiality of HIV related information.

3.6. Orange County Mental Health Plan Member Eligibility

MEMBER ELIGIBILITY VERIFICATION

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

The following resources are available to assist in eligibility verification:

TABLE 3-1: MEMBER ELIGIBILITY VERIFICATION TOOLS

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

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

The Beacon Clinical Department may also assist the provider in verifying the member's plan enrollment when authorizing services. Due to the implementation of the privacy act, Beacon requires the provider to have ready specific identifying information (provider ID#. member full name and date of birth) to avoid inadvertent disclosure of member sensitive health information.

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

Chapter 4

Quality Management and Improvement Program

4.1. Quality Management and Improvement Program Overview

TABLE 4-1: QM&I PROGRAM OVERVIEW

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

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

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

4.2. Quality Monitoring

Beacon monitors provider activity and uses the data generated to assess provider performance related to quality initiatives and specific core performance indicators. Findings related to provider compliance with performance standards and measures are also used in credentialing and recredentialing activities, benchmarking, and to identify individual provider and network-wide improvement initiatives. Beacon's quality monitoring activities include, but are not limited to:

- Site visits
- Provider utilization of practice guidelines
- Treatment record reviews
- Satisfaction surveys
- Timeliness and accuracy of claims payment
- Provider compliance with performance standards including, but not limited to:
    - Timeliness of ambulatory follow-up after mental health hospitalization
    - Discharge planning activities
    - Communication with member PCPs, other behavioral health providers, government and community agencies
    - Tracking of fraud and abuse, adverse incidents, complaints, grievances, and appeals
- Other quality improvement activities

On an annual basis, Beacon's QM&I Department aggregates and trends all data collected and presents the results to the Quality Improvement (QIC) Committee for review. The QIC may recommend initiatives at individual provider sites and throughout Beacon's behavioral health network as indicated.

A record of each provider's adverse incidents and any complaints, grievances, or appeals pertaining to the provider, is maintained in the provider's credentialing file, and may be used by Beacon in profiling, recredentialing, and network (re)procurement activities and decisions.

4.3. Treatment Records

TREATMENT RECORD REVIEWS

Beacon reviews member charts and uses data generated to monitor and measure provider performance in relation to the treatment record standards and specific quality initiatives established each year. The following elements are evaluated:

- Use of screening tools for diagnostic assessment of substance use, adolescent depression and ADHD
- Continuity and coordination with primary care providers and other treaters
- Explanation of member rights and responsibilities
- Inclusion of all applicable required medical record elements as listed below
- Allergies and adverse reactions; medications; physical exam

Beacon may conduct chart reviews onsite at a provider facility, or may ask a provider to copy and send specified sections of a member's medical record to Beacon. Any questions that a provider may have regarding Beacon's access to the plan member information should be directed to Beacon's privacy officer at compliance@beaconhealthoptions.com.

HIPAA regulations permit providers to disclose information without patient authorization for the following reasons: "oversight of the health care system, including quality assurance activities." Beacon chart reviews fall within this area of allowable disclosure (See Chapter 3).

TREATMENT RECORD STANDARDS

To ensure that the appropriate clinical information is maintained within the member's treatment record, providers must follow the documentation requirements below, based upon NCQA standards. All documentation must be clear and legible.

TABLE 4-2: TREATMENT DOCUMENTATION STANDARDS

Member Identification Information	The treatment record contains the following member information: ▪ Member name and Plan ID # on every page ▪ Member's address ▪ Employer or school ▪ Home and work telephone # ▪ Marital/legal status ▪ Appropriate consent forms ▪ Guardianship information, if applicable
Informed Member Consent for Treatment	The treatment record contains signed consents for the following: ▪ Implementation of the proposed treatment plan ▪ Any prescribed medications ▪ Consent forms related to interagency communications ▪ Individual consent forms for release of information to the member's PCP and other behavioral health providers, if applicable; each release of information to a new party (other than Beacon or the plan) requires its own signed consent form ▪ Consent to release information to the payer or MCO (In doing so, the provider is communicating to the member that treatment progress and attendance will be shared with the payer.) ▪ For adolescents, ages 12–17, the treatment record contains consent to discuss behavioral health issues with their parents ▪ Signed document indicating review of patient's rights and responsibilities

Medication Information	Treatment records contain medication logs clearly documenting the following: ▪ All medications prescribed ▪ Dosage of each medication ▪ Dates of initial prescriptions ▪ Information regarding allergies and adverse reactions are clearly noted ▪ Lack of known allergies and sensitivities to substances are clearly noted
Medical and Psychiatric History	Treatment record contains the member's medical and psychiatric history including: ▪ Previous dates of treatment ▪ Names of providers ▪ Therapeutic interventions ▪ Effectiveness of previous interventions ▪ Sources of clinical information ▪ Relevant family information ▪ Results of relevant laboratory tests ▪ Previous consultation and evaluation reports
Adolescent Depression Information	Documentation for any member 13-18 years who was screened for depression: ▪ If yes, was a suicide assessment conducted? ▪ Was the family involved with treatment?
ADHD Information	Documentation that members aged 6-12 were assessed for ADHD ▪ Was family involved with treatment? ▪ Is there evidence of the member receiving psychopharmacological treatment?
Diagnostic Information	▪ Risk management issues (e.g., imminent risk of harm, suicidal ideation/intent, and elopement potential) are prominently documented and updated according to provider procedures ▪ All relevant medical conditions are clearly documented, and updated as appropriate ▪ Member's presenting problems and the psychological and social conditions that affect their medical and psychiatric status

	▪ A complete mental status evaluation is included in the treatment record, which documents the member's: a. Affect b. Speech c. Mood d. Thought control, including memory e. Judgment f. Insight g. Attention/concentration h. Impulse control i. Initial diagnostic evaluation and DSM diagnosis that is consistent with the stated presenting problems, history, mental status evaluation, and/or other relevant assessment information j. Diagnoses updated at least quarterly basis
Treatment Planning	The treatment record contains clear documentation of the following: ▪ Initial and updated treatment plans consistent with the member's diagnoses, goals, and progress ▪ Objective and measurable goals with clearly defined time frames for achieving goals or resolving the identified problems ▪ Treatment interventions used and their consistency with stated treatment goals and objectives ▪ Member, family, and/or guardian's involvement in treatment planning, treatment plan meetings and discharge planning ▪ Copy of *Outpatient Review Form(s)* submitted, if applicable
Treatment Documentation	The treatment record contains clear documentation of the following: ▪ Ongoing progress notes that document the member's progress towards goals, as well as his/her strengths and limitations in achieving said goals and objectives ▪ Referrals to diversionary levels of care and services if the member requires increased interventions resulting from homicidality, suicidality or the inability to function on a day-to-day basis ▪ Referrals and/or member participation in preventive and self-help services (e.g., stress management, relapse prevention, Alcoholics Anonymous, etc.) is included in the treatment record. ▪ Member's response to medications and somatic therapies

Coordination and Continuity of Care	The treatment record contains clear documentation of the following: ▪ Documentation of communication and coordination between behavioral health providers, primary care physicians, ancillary providers, and health care facilities. (See Behavioral Health – PCP Communication Protocol later in this chapter, and download *Behavioral Health – PCP Communication Form*) ▪ Dates of follow-up appointments, discharge plans, and referrals to new providers
Additional Information for Outpatient Treatment Records	These elements are required for the outpatient medical record: ▪ Telephone intake/request for treatment ▪ Face sheet ▪ Termination and/or transfer summary, if applicable ▪ The following clinician information on every entry (e.g., progress notes, treatment notes, treatment plan, and updates) should include the following treating clinician information: a. Clinician's name b. Professional degree c. Licensure d. NPI or Beacon identification number, if applicable e. Clinician signatures with dates
Additional Information for Inpatient and Diversionary Levels of Care	These elements are required for inpatient medical records: ▪ Referral information (ESP evaluation) ▪ Admission history and physical condition ▪ Admission evaluations ▪ Medication records ▪ Consultations ▪ Laboratory and x-ray reports ▪ Discharge summary and *Discharge Review Form*
Information for Children and Adolescents	A complete developmental history must include the following information: ▪ Physical, including immunizations ▪ Psychological ▪ Social ▪ Intellectual

	▪ Academic ▪ Prenatal and perinatal events are noted

4.4. Performance Standards and Measures

To ensure a consistent level of care within the provider network, and a consistent framework for evaluating the effectiveness of care, Beacon has developed specific provider performance standards and measures. Behavioral health providers are expected to adhere to the performance standards for each level of care they provide to members, which include, but are not limited to:

- Communication with PCPs, specialists, and other providers treating shared members
- Availability of routine, urgent, and emergent appointments (See Chapter 2)

4.5. Practice Guidelines

Beacon and the plan promote delivery of behavioral health treatment based on scientifically proven methods. Accordingly, we have researched and adopted evidenced-based guidelines for treating the most prevalent behavioral health diagnoses, including guidelines for ADHD and substance use disorders, as well as child/adolescent depression. Links to these guidelines can be found here on Beacon's website. We strongly encourage providers to use these guidelines and to consider these guidelines whenever they may promote positive outcomes for clients. Beacon monitors provider utilization of guidelines through the use of claim, pharmacy, and utilization data.

Beacon welcomes provider comments about the relevance and utility of the guidelines adopted by Beacon, 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 and the 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.

Beacon and the plan receive aggregate data by provider including demographic information and clinical and functional status without member-specific clinical information.

4.7. Continuity and Coordination of Care

Beacon and the plan share a commitment to full integration of medical and behavioral health care services. Effective coordination improves the overall quality of both primary care and behavioral health services by:

1. Supporting member access to needed medical and behavioral health services
2. Reducing the occurrence of over- and under-utilization
3. Increasing the early detection of medical and behavioral health problems

4. Facilitating referrals for appropriate services
5. Maintaining continuity of care

Beacon and the plan require PCPs and behavioral health providers to coordinate care through ongoing communication directly related to their patient's health status. With informed member consent, behavioral health providers are required to provide PCPs with information related to behavioral health treatment needs and current treatment plans of shared members. If a member is receiving treatment from more than one provider, the guidelines in this section apply to all providers.

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

COMMUNICATION BETWEEN OUTPATIENT BEHAVIORAL HEALTH PROVIDERS AND PCPS, OTHER TREATERS	COMMUNICATION BETWEEN INPATIENT/ DIVERSIONARY PROVIDERS AND PCPS, OTHER OUTPATIENT TREATERS
Outpatient behavioral health providers are expected to communicate with the member's PCP and other outpatient behavioral health providers if applicable, as follows: ▪ Notice of commencement of outpatient treatment within four visits or two weeks, whichever occurs first ▪ Updates at least quarterly during the course of treatment ▪ Notice of initiation and any subsequent modification of psychotropic medications ▪ Notice of treatment termination within two weeks Behavioral health providers may use Beacon's *Authorization for Behavioral Health Provider and PCP to Share Information Form* and the *Behavioral Health-PCP Communication Form* available for initial communication and subsequent updates, posted on the website. Providers may also use their own form that includes the following information: ▪ Presenting problem/reason for admission ▪ Date of admission ▪ Admitting diagnosis ▪ Preliminary treatment plan ▪ Currently prescribed medications ▪ Proposed discharge plan	With the member's informed consent, acute care facilities are expected to contact the PCP by phone and/or by fax, within 24 hours of a member's admission to treatment. Inpatient and diversionary providers must also alert the PCP 24 hours prior to a pending discharge, and must fax or mail the following member information to the PCP within three days post-discharge: ▪ Date of discharge ▪ Diagnosis ▪ Medications ▪ Discharge plan ▪ Aftercare services for each type, including: ○ Name of provider ○ Date of first appointment ○ Recommended frequency of appointments ○ Treatment plan Inpatient and diversionary providers must make every effort to provide the same notifications and information to the member's outpatient therapist, if there is one. Acute care providers' communication requirements are addressed during continued stay and discharge reviews 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 three business days of the request to include the following health information: ▪ Status of immunizations ▪ Date of last visit ▪ Dates and reasons for any and all hospitalizations ▪ Ongoing medical illness ▪ Current medications ▪ Adverse medication reactions, including sensitivity and allergies ▪ History of psychopharmacological trials Outpatient providers' compliance with communication standards is monitored through requests for authorization submitted by the provider, and through chart reviews.	

4.8. 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 member and the receiving provider.

Routine outpatient behavioral health treatment by an out-of-network provider is not an authorized service covered by Beacon. Members may be eligible for transitional care within 30 days after joining the health plan, or to ensure that services are culturally and linguistically sensitive, individualized to meet the specific needs of the member, timely per Beacon's timeliness standards, and/or geographically accessible.

4.9. Reportable Incidents and Events

Beacon requires that all providers report adverse incidents, other reportable incidents, and sentinel events involving the plan members to Beacon as follows:

TABLE 4-4: REPORTABLE INCIDENTS AND EVENTS - OVERVIEW

	ADVERSE INCIDENTS	SENTINEL EVENTS	OTHER REPORTABLE INCIDENTS
Incident/Event Description	An adverse incident is an occurrence that represents actual or potential serious harm to the well-being of a plan member who is currently receiving or has been recently discharged from behavioral health services.	A sentinel event is any situation occurring within or outside of a facility that either results in death of the member or immediately jeopardizes the safety of a plan member receiving services in any level of care.	An "other reportable incident" is any incident that occurs within a provider site at any level of care, which does not immediately place a plan member at risk but warrants serious concern.
Incidents/ Events Include the Following	▪ All medico-legal or non-medico-legal deaths ▪ Any absence without authorization (AWA) involving a member ▪ Any injury while in a 24-hour program that could, or did, result in transportation to an acute care hospital for medical treatment or hospitalization ▪ Any sexual assault or alleged sexual assault ▪ Any physical assault or alleged physical assault by a staff person or another patient against a member ▪ Any medication error or suicide attempt that requires medical attention beyond general first aid procedures ▪ Any unscheduled event that results in the evacuation of a	▪ All medico-legal deaths ▪ Any medico-legal death required to be reported to the medical examiner or in which the medical examiner takes jurisdiction ▪ Any AWA involving a patient involuntarily admitted or committed and/or who is at high risk of harm to self or others ▪ Any serious injury resulting in hospitalization for medical treatment ▪ A serious injury, defined as any injury that requires the individual to be transported to an acute care hospital for medical treatment and is subsequently medically admitted. ▪ Any medication error or suicide attempt that requires medical attention beyond	▪ Any non-medico-legal deaths ▪ Any AWA from a facility involving a member who does not meet the criteria for a sentinel event as described above ▪ Any physical assault or alleged physical assault by or against a member that does not meet the criteria of a sentinel event ▪ Any serious injury while in a 24-hour program requiring medical treatment, but not hospitalization ▪ A serious injury, defined as any injury that requires the individual to be transported to an acute care hospital for medical treatment and is not subsequently medically admitted

	ADVERSE INCIDENTS	SENTINEL EVENTS	OTHER REPORTABLE INCIDENTS
	program or facility (e.g., fire resulting in response by fire department)	general first aid procedures ▪ Any sexual assault or alleged sexual assault ▪ Any physical assault or alleged physical assault by a staff person against a member ▪ Any unscheduled event that results in the evacuation of a program or facility whereby regular operations will not be in effect by the end of the business day and may result in the need for finding alternative placement options for member	▪ Any unscheduled event that results in the temporary evacuation of a program or facility, such as a small fire that requires fire department response. Data regarding critical incidents are gathered in the aggregate and trended on a quarterly basis for the purpose of identifying opportunities for quality improvement
Reporting Method	▪ Beacon's Clinical Department is available 24 hours a day. ▪ Providers must call, regardless of the hour, to report such incidents. ▪ Providers should direct all such reports to their Beacon clinical manager or UR clinician by phone. ▪ In addition, providers are required to fax a copy of *the Adverse Incident Report Form* (for adverse and other reportable incidents and sentinel events) to Beacon's Ombudsperson at 888.204.5581. ▪ Incident and event reports should not be emailed unless the provider is using a secure messaging system.		
Provide the Following	Providers should be prepared to present: ▪ All relevant information related to the nature of the incident ▪ The parties involved (names and telephone numbers) ▪ The member's current condition		

4.10. Fraud and Abuse

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

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

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

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

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

4.11. Federal False Claims Act

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

SUMMARY OF PROVISIONS

The FCA imposes civil liability on any person who knowingly:

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

PENALTIES

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

QUI TAM (WHISTLEBLOWER) PROVISIONS

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

After the 60-day period or any extensions have expired, the government may pursue the matter in its own name, or decline to proceed. If the government declines to proceed, the person bringing the action has the right to conduct the action on their own in federal court. If the government proceeds with the case, the *qui tam* relator bringing the action will receive between 15 and 25 percent of any proceeds, depending upon the contribution of the individual to the success of the case. If the government declines to pursue the case, the successful *qui tam* relator will be entitled to between 25 and 30 percent of the proceeds of the case, plus reasonable expenses and attorney fees and costs awarded against the defendant.

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

NON-RETALIATION AND ANTI-DISCRIMINATION

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

REDUCED PENALTIES

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

If any member or provider becomes aware of any potential fraud by a member or provider, please contact us at 781.994.7500 and ask to speak to the Compliance Officer.

4.12. Complaints

Providers with complaints or concerns should contact Beacon at 800.723.8641 (TTY 866.727.9441) and ask to speak with the clinical manager for the plan. All provider complaints are thoroughly researched by Beacon and resolutions are proposed within 20 business days.

If a plan member complains or expresses concern regarding Beacon's procedures or services, plan procedures, covered benefits or services, or any aspect of the member's care received from providers, they should be directed to call Beacon's Ombudsperson at 800.723.8641 (TTY 866.727.9441).

4.13. Grievances and Appeals of Grievances

A grievance is any expression of dissatisfaction by a member, member representative, or provider about any action or inaction by Beacon other than an adverse action. Possible subjects for grievances include, but are not limited to, quality of care or services provided; Beacon's procedures (e.g., utilization review, claims processing); Beacon's network of behavioral health services; member billing; aspects of interpersonal relationships, such as rudeness of a provider or employee of Beacon; or failure to respect the member's rights.

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

Providers may register their own grievances and may also register grievances on a member's behalf. Members, or their guardian or representative on the member's behalf, may also register grievances. Call 800.723.8641 (TTY 866.727.9441) to register a grievance.

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

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

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

Chapter 5

Utilization Management

5.1. Utilization Management

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

Beacon'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 Beacon employees with responsibility for making UM decisions have been made aware that:

- All UM decisions are based upon the Medical Necessity Criteria for Mental Health Reimbursement of Specialty Mental Health Services as defined in Section 1830.205 of the Title IX California Code of Regulations.
- 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.

5.2. Medical Necessity

MEDICAL NECESSITY

§ 1830.205. Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services

(a) The following mental health necessity criteria determine Medi-Cal reimbursement for Specialty Mental Health Services that are the responsibility of the Mental Health Plan (MHP) under this subchapter, except as specialty provided.

(b) The beneficiary must meet criteria outlined in 1, 2, and 3 below to be eligible for services:

(1) Be diagnosed by MHP with one of the following diagnoses in DSM:

a. Pervasive developmental disorders (except Autistic disorders)

b. Disruptive behavior and attention deficit disorders

c. Feeding and eating disorders of infancy or early childhood

d. Elimination disorders

e. Other disorders of infancy, childhood, or adolescence

f. Schizophrenia or other psychotic disorders

g. Mood disorders

h. Anxiety disorders

i. Somatoform disorders

j. Factitious disorders

k. Dissociative disorders

l. Paraphilia disorders

m. Gender identity disorders

n. Eating disorders

o. Impulse control disorders

p. Adjustment disorders

q. Personality disorders, except antisocial personality disorders

r. Medication-induced movement disorders related to other included diagnoses

(2) Must have one of these impairments as a result of a diagnosis above:

a. Significant impairment in an important area of life functioning

b. Probability of significant deterioration in an important area of life functioning

c. Probability a child (under 21 years) will not progress developmentally as individually appropriate

(3) Must meet each of the intervention criteria listed below:

a. Focus of intervention is to address the condition identified in 2 above

b. The expectation is that the proposed intervention will:

i. Significantly diminish the impairment

ii. Prevent significant deterioration in an important area of life functioning

iii. Except as provided in Section 1830.10, allow the child to progress developmentally as individually appropriate

c. The condition would not be responsive to physical health care-based treatment

§ 1830.210 Medical Necessity Criteria for MHP Reimbursement for Specialty MH Services for Eligible Beneficiaries Under 21 Years of Age

(a) For beneficiaries under 21 years of age who do not meet the medical necessity requirements of Section 1830.205(b) (2) and (3), medical necessity criteria for Specialty Mental Health Services covered by this subchapter shall be met when all of the following exist:

(1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1)

(2) The beneficiary has a condition that would not be responsive to physical health care-based treatment

(3) The requirements of Title 22, Section 51340(e)(3) are met, or for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3) and the requirements of Title 22, Section 51340(f) are met

(b) The MHP shall not approve a request for an EPSDT Supplemental Specialty Mental Health Service under this section if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another Specialty Mental Health Service covered by this subchapter.

(c) The MHP shall not approve a request for Specialty Mental Health Services under this section in home- and community-based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner.

5.3. Level of Care Criteria (LOCC)

Beacon's clinical staff will evaluate requests for Specialty Mental Health Outpatient Services based on the Medical Necessity Criteria for Mental Health Reimbursement of Specialty Mental Health Services as defined in Section 1830.205 of the Title IX California Code of Regulations. This criteria is accessible through eServices; providers can also contact us to request a printed copy of this criteria.

The criteria are applied to determine appropriate care for all members. In general, members are certified only if they meet the specific medical necessity criteria for a particular level of care. However, the individual's needs and characteristics of the local service delivery system are taken into consideration.

5.4. 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 Beacon's UM reviews and decision-making. All determinations are based upon review of the information provided and available to Beacon at the time.

TABLE 5-1: UM TERMS AND DEFINITIONS

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: a. Failure to meet the requirements for coverage based on medical necessity b. Appropriateness of health care setting and level of care effectiveness c. Plan benefits
Adverse Action	The following actions or inactions by Beacon or the provider organization: 1. Beacon'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 2. Beacon's denial or limited authorization of a requested service, including the determination that a requested service is not a covered service 3. Beacon's reduction, suspension, or termination of a previous authorization for a service

TERM	DEFINITION
	4. Beacon'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: a. Failure to follow prior authorization procedures b. Failure to follow referral rules c. Failure to file a timely claim 5. Beacon's failure to act within the time frames for making authorization decisions 6. Beacon's failure to act within the time frames for making appeal decisions
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	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, based on a prudent layperson's judgment ▪ 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

TERM	DEFINITION
Urgent Pre-Service Decision	Formerly known as a pre-certification decision, any case or service that must be approved before a member obtains care or services in an inpatient setting, for a member whose condition meets the definition of urgent care above. An urgent pre-service decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment in an acute treatment setting.

5.5. Authorization Procedures and Requirements

This section describes the processes for obtaining authorization for Specialty Mental Health Services and for Beacon's medical necessity determinations and notifications. In all cases, the treating provider 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 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 plan member identification card does not guarantee that the member is eligible for benefits. Providers are strongly encouraged to check Beacon's eServices or by calling IVR at 888.210.2018.

BEACON CLINICIAN AVAILABILITY

All Beacon clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention triage and referral procedures. Beacon clinicians are available 24 hours a day, seven days a week to take emergency calls from members, their guardians, and providers.

TABLE 5-2: AUTHORIZATION PROCEDURES AND REQUIREMENTS

AUTHORIZATION PROCEDURES AND REQUIREMENTS	
Services Requiring Authorization	All services require prior authorization
Exceptions from Authorization	▪ Emergency services do not require pre-service authorization; however, facilities must notify Beacon of the emergency treatment and/or admission within 24 hours ▪ Attending fees
Extended authorization	▪ If a provider wishes to begin or continue treatment after a member has exhausted his or her initial authorization, or to

	continue treatment beyond completion of an existing outpatient authorization, he or she must submit an *Electronic Outpatient Review Form* (eORF) via Beacon's eServices. The extended authorization request should be submitted approximately two weeks before the additional visits are scheduled.
Notice of Authorization Determination	▪ Members must be notified of all pre-service and concurrent denial decisions. ▪ The denial notification letter sent to the member or member's guardian, practitioner, and/or provider includes the specific reason for the denial decision; the member's presenting condition, diagnosis, and treatment interventions; the reason(s) why such information does not meet 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 Beacon, if any. Based on state and/or federal statutes, an explanation of the member's appeal rights and the appeals process is enclosed with all denial letters. ▪ Beacon's outpatient authorization decisions are posted on eServices, whether approved, modified, or denied, within the decision timeframe specified below. Providers receive an email message, alerting them that a determination has been made. ▪ Beacon also faxes an authorization letter to the provider if requested. However, Beacon strongly encourages 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 timeframe within which the authorized visits may be used, and an explanation of any modifications made by Beacon. ▪ Denials for extended outpatient services may be appealed by the member or provider and are subject to the reconsideration process outlined in Chapter 6.

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

INADEQUATE OR INCOMPLETE CLINICAL REVIEW

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

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, (Babel Card).

TERMINATION OF OUTPATIENT CARE

Beacon requires that all outpatient providers set specific termination goals and discharge criteria for members. Providers are encouraged to use the LOCC documented in Chapter 8 (accessible through eServices) to determine whether the service meets medical necessity for continuing outpatient care.

5.6. Decision and Notification Time Frames

Beacon 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. Beacon has adopted the strictest time frame for all UM decisions in order to comply with the various requirements.

The time frames below present Beacon's internal time frames for rendering a UM determination, and notifying members of such determination. All time frames begin at the time of Beacon's 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.

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

TABLE 5-4: DECISION AND NOTIFICATION TIME FRAMES

	TYPE OF DECISION	DECISION TIME FRAME	VERBAL NOTIFICATION	WRITTEN NOTIFICATION
Pre-Service Review				
Initial Authorization for Other Urgent Behavioral Health Services	Urgent	Within 24 hours	Within 24 hours	Within 24 hours
Initial Authorization for Non-Urgent Behavioral Health Services	Standard	Within 14 calendar days	Within 14 calendar days	Within 14 calendar days
Concurrent Review				
Continued Authorization for Inpatient and Other Urgent Behavioral Health Services	Urgent/ Expedited	Within 1 business day	Within 1 business day	Within 1 business day

	TYPE OF DECISION	DECISION TIME FRAME	VERBAL NOTIFICATION	WRITTEN NOTIFICATION
Continued Authorization for Non-Urgent Behavioral Health Services	Non-Urgent/ Standard	Within 14 calendar days	Within 14 calendar days	Within 14 calendar days
Post-Service				
Authorization for Behavioral Health Services Already Rendered	Non-Urgent/ Standard	Within 14 calendar days	Within 14 calendar days	Within 14 calendar days

Chapter 6

Clinical Reconsiderations and Appeals

6.1. Request for Reconsideration of Adverse Determination

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

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

6.2. Clinical Appeals Process

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

Appeal policies are made available to members and/or their appeal representatives as enclosures in all denial letters and upon request.

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

PEER REVIEW

A peer review conversation may be requested at any time by the treating provider, and may occur prior to or after an adverse determination, upon request for a reconsideration. Beacon UR clinicians and physician advisors are available daily to discuss denial cases by phone at 800.723.8641.

URGENCY OF APPEAL PROCESSING

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

DESIGNATION OF AUTHORIZED MEMBER REPRESENTATIVE (AMR)

If the member is designating an appeal representative to appeal on his or her behalf, the member must notify a mental health plan representative at 866.308.3074 or write to:

Behavioral Health Services
QIPC
P.O. Box 355
Santa Ana, CA 92702-0355

Members must notify the Mental Health Plan prior to the deadline for resolving the appeal. Failure to do so will result in dismissal of the appeal. In cases where the appeal is expedited, a provider may initiate appeal without written consent from the member.

APPEALS PROCESS DETAIL

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

1. Table 6-1: Expedited Clinical Appeals
2. Table 6-2: Standard Clinical Appeals

Each table illustrates:

- How to initiate an appeal
- Member beneficiary requirements
- Resolution and notification time frames for expedited and standard clinical appeals at the first, second, and external review levels

TABLE 6-1: EXPEDITED CLINICAL APPEALS

ORANGE COUNTY MEDI-CAL	
LEVEL 1 APPEAL	**EXTERNAL REVIEW**
Members, their legal guardian, or their authorized representative have up to 90 calendar days after receiving notice of action in which to file an appeal. In the event that a member does not receive a notice of action regarding an appealable event, there is no deadline to file an appeal request. The appeal may be requested in writing or verbally. Both verbal and written communication can take place with a provider who initiated the expedited appeal or with the individual who the member verbally designated as their authorized representative. In the event the Mental Health Plan determines a member does not qualify for an expedited appeal, Beacon will notify the member, their legal guardian, or their authorized representative within two calendar days. A physician advisor, not involved in the initial decision, will review available information and attempt to contact the member's attending physician/provider. The Mental Health Plan will render a decision within three business days of the appeal filing date. The Mental Health Plan will notify all parties involved in the appeal both verbally and in writing.	Members, their legal guardian, or their authorized representative has the right to file for a State Fair Hearing after or in lieu of filing a Level 1 Appeal with the Mental Health Plan. The Mental Health Plan will provide the State with all documentation relating to the appeal. Members, their guardian, or authorized representative, must file for a State Fair Hearing within three business days after receiving a notice of action. However, the appeal request must be filed within 10 days of a notice of action in order to continue services without liability.

ORANGE COUNTY MEDI-CAL	
LEVEL 1 APPEAL	**EXTERNAL REVIEW**
Throughout the course of an appeal, the member may continue to receive services without liability for services previously authorized by Beacon until he/she is notified of the appeal determination. For this to occur, the request to file an appeal must be received within 10 days of the date on the Notice of Action Form. However, the member may be held liable for payment of continuing services if the appeal is not deemed in their favor.	
Contact Information Appeal requests can be made by calling a Mental Health Plan representative at 866.308.3074 or writing to: Behavioral Health Services QIPC P.O. Box 355 Santa Ana, CA 92702-0355	**Contact Information** Fair Hearing requests can be made by calling the California Department of Social Services' State Hearings Division at 800.952.5253 or in writing to: State Hearings Division California Department of Social Services P.O. Box 9424443, Mail Station 19-37 Sacramento, CA 94244-2430

Please note that providers may act as a member's appeal representative.

TABLE 6-2: STANDARD CLINICAL APPEALS

ORANGE COUNTY MEDI-CAL	
LEVEL 1 APPEAL	**EXTERNAL REVIEW**
Members, their legal guardian, or their authorized representative have up to 90 calendar days after receiving notice of action in which to file an appeal. In the event that a member does not receive a notice of action regarding an appealable event, there is no deadline to file an appeal request. The appeal may be requested in writing or verbally. All verbal requests for a standard appeal must be followed by a written request; however, the verbal appeal is the filing day. Both verbal and written communication can take place with a provider who initiated the expedited appeal or with the individual who the member verbally designated as their authorized representative.	Members, their legal guardian, or their authorized representative has the right to file for a State Fair Hearing after or in lieu of filing a Level 1 Appeal with the Mental Health Plan. The Mental Health Plan will provide the State with all documentation relating to the appeal. Members, their legal guardian, or their authorized representative, must file for a State Fair Hearing within 90 days after receiving a notice of action. However, the appeal request must be filed within 10 days of notice of action in order to continue services without liability.

ORANGE COUNTY MEDI-CAL	
LEVEL 1 APPEAL	**EXTERNAL REVIEW**
A physician advisor, not involved in the initial decision, will review available information and attempt to contact the member's attending physician/provider. The Mental Health Plan will render a decision within 45 calendar days of the appeal filing date. Beacon will notify all parties involved in the appeal both verbally and in writing. A standard appeal may require review of medical records (post-service situations). The member's or the authorized representative's signature is required on an *Authorization to Release Medical Information Form* authorizing the release of medical and treatment information relevant to the appeal. If the medical record with *Authorization to Release Medical Information Form* is not received prior to the deadline for resolving the appeal, a resolution will be rendered based on the information available. Throughout the course of an appeal, the member may continue to receive services without liability for services previously authorized by Beacon until he/she is notified of the appeal determination. For this to occur, the request to file an appeal must be received within 10 days of the date on the Notice of Action Form. However, the member may be held liable for payment of continuing services if the appeal is not deemed in their favor.	
Contact Information Appeal requests can be made by calling a Mental Health Plan representative at 866.308.3074 or writing to: Behavioral Health Services QIPC P.O. Box 355 Santa Ana, CA 92702-0355	**Contact Information** Fair Hearing requests can be made by calling the California Department of Social Services' State Hearings Division at 800.952.5253 or in writing to: State Hearings Division California Department of Social Services P.O. Box 9424443, Mail Station 19-37 Sacramento, CA 94244-2430

6.3. Administrative Appeals Process

A provider may submit an administrative appeal when Beacon denies payment based on the provider's failure to following administrative procedures for authorization. (Note that the provider may not bill the member for any services denied on this basis.)

Providers must submit their appeal concerning administrative operations to the Beacon Ombudsperson or Appeals Coordinator no later than 60 days from the date of their receipt of the administrative denial decision. The Ombudsperson or Appeals Coordinator instructs the provider to submit in writing the nature of the grievance and documentation to support an overturn of Beacon's initial decision.

The following information describes the process for first and second level administrative appeals:

- **First Level** administrative appeals for Medi-Cal members should be submitted in writing to the Appeals Coordinator at Beacon. Provide any supporting documents that may be useful in making a decision. (Do not submit Medical Records or any clinical information.) An administrative appeals committee reviews the appeal and a decision is made within 20 business days of date of receipt of appeal. A written notification is sent within three business days of the appeal determination.
- **Second Level** administrative appeals for Medi-Cal members should be submitted in writing to the Chief Operations Officer at Beacon. A decision is made within 20 business days of receipt of appeal information and notification of decision is sent within three business days of appeal determination

Chapter 7

Billing Transactions

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

7.1. General Claims Policies

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

DEFINITION OF "CLEAN CLAIM"

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

ELECTRONIC BILLING REQUIREMENTS

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

PROVIDER RESPONSIBILITY

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

LIMITED USE OF INFORMATION

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

PROHIBITION OF BILLING MEMBERS

Providers are not permitted to bill 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 received pending correction or explanation.

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

reports 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 days from the date on which Beacon receives the claim.

7.2. Coding

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

- Providers are required to submit HIPAA-compliant coding on all claim submissions; this includes HIPAA-compliant revenue, CPT, HCPCS and ICD-10 codes. Providers should refer to their exhibit A for a complete listing of contracted, reimbursable procedure 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, as listed in the table below. 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.

	302.8 – 302.9	311 – 313.82
299.1 – 300.89	307.1	313.89 – 314.9
301.0 – 301.6	307.3	332.1 – 333.99
301.8 – 301.9	307.5 – 307.89	787.6
302.1 – 302.6	308.0 – 309.9	

TABLE 7-1: BILL TYPE CODES

TYPE OF FACILITY – 1ST DIGIT	BILL CLASSIFICATIONS – 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 90 days of the dates of service on outpatient claims

Providers are encouraged to submit claims using best efforts within 30 days from the date services were rendered for prompt adjudication. Claims submitted after the 90-day filing limit will deny unless submitted as a waiver or reconsideration request, as described in this chapter.

In addition, providers should look solely to Beacon (or to another carrier, as the case may be) for payment for services and with the exception of co-payments, should not request payment from any member.

7.3. Coordination of Benefits (COB)

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

- When it is determined that Beacon is the secondary payer, claims must be submitted with a copy of the primary insurance's explanation of benefits report and received by Beacon within 90 days of the date on the other carrier's 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 education and Outreach

SUMMARY

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

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

HOW THE PROGRAM WORKS

- A quarterly approval report is generated that lists the percentage of claims paid in relation to the volume of claims submitted.
- All providers below 75 percent 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.

SHARE-OF-COST

Share-of-cost shall be the network provider's responsibility to collect form the beneficiary. Providers shall:

- Verify share-of-cost amounts through the Medi-Cal website, AEVS, or POS and update Beacon on the amount actually collected within one business day of providing services.
- Notify the beneficiary of his/her share-of-cost obligation
- Send in a claim form reflecting the gross amount, share-of-cost amount (if applicable), and the balance due after the share-of-cost has been met
- If there is not a balance due after the share-of-cost has been met, the provider shall send in a claim form for encounter data collection with a "$0" balance due

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@beaconhealthoptions.com

Telephone

- **Interactive Voice Recognition (IVR): 888.210.2018**
  You will need your practice or organization's tax ID, the member's identification number and date of birth, and the date of service.
- **Claims Hotline: 800.723.8641**
  Hours of operation are 8:30 a.m. to 5:30 p.m., Monday through Thursday; 9 a.m. to 5 p.m., Friday
- **Beacon's Main Telephone Numbers**

EDI	888.204.5581
TTY	866.727.9441

7.5. Electronic Submission of Claims

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

- **Electronic Data Interchange (EDI)** supports electronic submission of claim batches in HIPAA-compliant 837P format for professional services and 837I format for institutional services. Providers may submit claims using EDI/837 format directly to Beacon or through a billing intermediary. If using Emdeon as the billing intermediary, two identification numbers must be included in the 837 file for adjudication:
    - Beacon's payor ID is 43324.
    - Beacon's health plan-specific ID is 158.
- **eServices** enables providers to submit inpatient and outpatient claims without completing a CMS 1500 or UB04 claim form. Because much of the required information is available in Beacon's database, most claim submissions take less than one minute and contain few, if any errors.
- **IVR** provides telephone access to member eligibility, claims status, and authorization status.

7.6. Claims Transaction Overview

Table 7-2 below identifies all claim transactions, indicates which transactions are available on each of the electronic media, and provides other information necessary for electronic completion. Watch for updates as additional transactions become available on EDI, eServices and IVR.

TABLE 7-2: CLAIMS TRANSACTION OVERVIEW

TRANSACTION	ACCESS ON:			APPLICABLE WHEN:	TIME FRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
	EDI	ESERVICES	IVR			
Member Eligibility Verification	Y	Y	Y	Completing any claim transaction; and Submitting clinical authorization requests	N/A	N/A
Submit Standard Claim	Y	Y	N	Submitting a claim for authorized, covered services, within the timely filing limit	Best efforts for 30 days; must be received within 90 days after the date of service	N/A

TRANSACTION	ACCESS ON:			APPLICABLE WHEN:	TIME FRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
	EDI	ESERVICES	IVR			
Request to Void Payment	N	N	N	Claims was paid to provider in error Provider needs to return the entire paid amount to Beacon	N/A	***Do NOT send a refund check to Beacon.***
Request for Adjustment	Y	Y	N	The amount paid to provider on a claim was incorrect Adjustment may be requested to correct: ▪ Underpayment (positive request) ▪ Overpayment (negative request)	Positive request must be received by Beacon within 90 days from the date of original payment. No filing limit applies to negative requests.	▪ ***Do NOT send a refund check to Beacon.*** ▪ ***A Rec ID is required to indicate that claim is an adjustment.*** ▪ Adjustments are reflected on a future EOB as recoupment of the previous (incorrect) amount, and if money is owed to provider, repayment of 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

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

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

PAPER CLAIMS TRANSACTIONS

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

For paper submissions, providers are required to submit clean claims on the National Standard Format CMS 1500 or UB04 claim form. No other forms are accepted.

Mail paper claims to:

Beacon Health Options
OCHCA Claims Department
5665 Plaza Drive, Suite 400
Cypress, CA 90630

Beacon Discourages Paper Transactions

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

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

Professional Services: Instructions for Completing the CMS 1500 Form

Table 7-3 below lists each numbered block on the CMS 1500 form with a description of the requested information, and indicates which fields are required in order for a claim to process and pay.

Table 7-3: CMS 1500 Form

TABLE BLOCK #	REQUIRED?	DESCRIPTION
1	No	Check Applicable Program
1a	Yes	Member's Health Plan ID Number
2	Yes	Member's Name
3	Yes	Member's Birth Date and Sex
4	Yes	Insured's Name
5	Yes	Member's Address
6	No	Member's Relationship to Insured
7	No	Insured's Address
8	Yes	Member's Status
9	Yes	Other Insured's Name (if applicable)
9a	Yes	Other Insured's Policy or Group Number
9b	Yes	Other Insured's Date of Birth and Sex
9c	Yes	Employer's Name or School Name
9d	Yes	Insurance Plan Name or Program Name
10a-c	Yes	Member's Condition Related to Employment
11	No	Member's Policy, Group or FICA Number (if applicable)
11a	No	Member's Date of Birth (MM, DD, YY) and Sex (check box)
11b	No	Employer's Name or School Name (if applicable)

TABLE BLOCK #	REQUIRED?	DESCRIPTION
11c	No	Insurance Plan Name or Program Name (if applicable)
11d	No	Is there another health benefit plan?
12	Yes	Member's or Authorized Person's Signature and Date on File
13	No	Member's or Authorized Person's Signature
14	No	Date of Current Illness
15	No	Date of Same or Similar Illness
16	No	Date Client Unable to Work in Current Occupation
17	No	Name of Referring Physician or Other Source (if applicable)
17b	No	NPI of Referring Physician
18	No	Hospitalization dates Related to Current Services (if applicable)
19	Yes	Former Control Number (Record ID if applicable)
20	No	Outside Lab?
21	Yes	Diagnosis or Nature of Illness or Injury.
22	No	Medicaid Resubmission Code
23	Yes	Prior Authorization Number (if applicable)
24a	Yes	Date of Service
24b	Yes	Place of Service Code (HIPAA-compliant)
24d	Yes	Procedure Code (HIPAA compliant between 290 and 319) and Modifier, when applicable
24e	Yes	Diagnosis Pointer – 1, 2, 3, or 4
24f	Yes	Charges
24g	Yes	Days or Units
24h	No	EPSDT
24i	No	ID Qualifier

TABLE BLOCK #	REQUIRED?	DESCRIPTION
24j	Yes	Rendering Provider Name and Rendering Provider NPI
25	Yes	Federal Tax ID Number
26	No	Provider's Member Account Number
27	No	Accept Assignment (check box)
28	Yes	Total Charges
29	Yes	Amount Paid by Other Insurance (if applicable)
30	Yes	Balance Due
31	Yes	Signature of Physician/Practitioner
32	Yes	Name and address of facility where services were rendered (Site ID). If missing, a claims specialist will chose the site shown as 'primary' in beacon's database.
32a	No	NPI of Servicing Facility
33	Yes	Provider Name
33a	Yes	Billing Provider NPI
33b	No	Pay to Provider Beacon ID Number

Institutional Services: Instructions for Completing the UB04 Form

Table 7-4 below lists each numbered block on the UB04 form with a description of the requested information and whether that information is required in order for a claim to process and pay.

Table 7-4: UB 04 Claim Form

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)

TABLE BLOCK #	REQUIRED?	DESCRIPTION
7	Yes	Covered Days (do not include date of discharge)
8	Yes	Member Name
9	Yes	Member Address
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	REC.ID for Resubmission
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

TABLE BLOCK #	REQUIRED?	DESCRIPTION
46	Yes	Units of Service
47	Yes	Total Charges
48	No	Non-Covered Charges
49	Yes	Modifier (if applicable)
50	Yes	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	Document Control Number
65	No	Employer Name
66	No	Employer Location
67	Yes	Principal Diagnosis Code
68	No	A-Q Other Diagnosis
69	Yes	Admit Diagnosis

TABLE BLOCK #	REQUIRED?	DESCRIPTION
70	No	Patient Reason Diagnosis
71	No	PPS Code
72	No	ECI
73	No	Unassigned
74	No	Principal Procedure
75	No	Unassigned
76	Yes	Attending Physician NPI – First and Last Name (required)
77	No	Operating Physician NPI/TPT
78-79	No	Other NPI
80	No	Remarks
81	No	Code-Code

PAPER RESUBMISSION

See Table 7-2 for an explanation of claim resubmission, when resubmission is appropriate, and procedural guidelines.

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

Paper Submission of *90-Day Waiver Form*

- See Table 7-2 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 *90-Day Waiver Form*
- Complete a *90-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 Claims Department
  90-Day Waivers
  5665 Plaza Drive, Suite 400
  Cypress, CA 90630

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

PAPER REQUEST FOR ADJUSTMENT OR VOID

See Table 7-2 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:

Beacon Claims Department
Adjustment Requests
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801-3393

To Complete the *Adjustment/Void Request Form*

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

1. **Provider Name**
   Enter the name of the provider to whom the payment was made
2. **Provider ID Number**
   Enter the Beacon provider ID number of the provider that was paid for the service. If the claim was paid under an incorrect provider number, the claim must be voided, and a new claim must be submitted with the correct provider ID number.
3. **Member Name**
   Enter the member's name as it appears on the EOB. If the payment was made for the wrong member, the claim must be voided, and a new claim must be submitted.
4. **Member ID Number**
   Enter the plan member ID number as it appears on the EOB. If a payment was made for the wrong member, the claim must be voided, and a new claim must be submitted.
5. **Beacon Record ID Number**
   Enter the record ID number as listed on the EOB.
6. **Beacon Paid Date**
   Enter the date the check was cut as listed on the EOB.
7. **Check Appropriate Line**
   Place an "X" on the line that best describes the type of adjustment/void being requested.
8. **Check all that Apply**
   Place an "X" on the line(s) that best describe the reason(s) for requesting the adjustment/void. If "Other" is marked, describe the reason for the request.

9. **Provider Signature**
   An adjustment/void request cannot be processed without a typed, signed, stamped, or computer-generated signature. Beacon will not accept “Signature on file.”
10. **Date**
    List the date that the form is signed