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.

# Beacon Autism Services Provider Manual

June 2021 (Revision date)

*Beacon Health Strategies is a Beacon Health Options, Inc. company.*

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Chapter 1

# Introduction

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## 1.1. Greetings!

Welcome to Beacon Autism Services! You are now a valued provider of a service that is committed to working with persons facing the challenges of autism spectrum disorder. We are delighted that you are joining our seamless and integrated system of clinical and administrative autism resources. Together we will deliver accountable, family-sensitive, outcome-focused care.

This handbook is your reference guide for navigating Beacon. As a contracted Beacon provider of clinical care, it is your responsibility to be familiar with and follow the policies and procedures outlined in this handbook. Each section of the handbook outlines our philosophy, our policies, and your responsibilities to Beacon and what you can expect from us.

## 1.2. 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.

The Manual serves as an administrative guide outlining Beacon's policies and procedures. Chapters 1- 4 discuss network participation, service provision, claims submission and quality management and improvement requirements. Detailed information regarding clinical processes, including authorizations, utilization review, case management, reconsiderations and appeals are found in chapters 5 - 6. Chapter 7 covers billing transactions.

Notification of updates to the Manual may be sent by postal mail and/or electronic mail. 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.

### MANUAL UPDATES AND GOVERNING LAWS

This manual is updated periodically as procedures are modified and enhanced. You will be notified a minimum of 30 calendar days prior to any material change to the manual unless otherwise required by regulatory or accreditation bodies.

This manual shall be governed by, and construed in accordance with, applicable federal, state and local laws.

## 1.3. Introduction to Beacon

Beacon Health Options (Beacon) mission is to partner with our health plan customers and contracted providers to improve the delivery of behavioral healthcare for the members we serve while helping our members to live their lives to the fullest potential.

Presently, the Beacon Health Options family of companies serves more than 48 million individuals on behalf of more than 350 client organizations across the country. Most often co-located at the physical location of our plan partners, Beacon's "in-sourced" approach deploys utilization 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.

## 1.4. About Beacon Autism Services

The Beacon Autism Services division of Beacon started as Autism Services Group (ASG), the first organized private sector human services entity focused exclusively on the quality management of autism insurance benefits. Specifically, ASG was acquired by Beacon in 2011 and continues to function as Beacon Autism Services. Beacon Autism Services is an administrative services organization working with health insurance plans, self-insured employers and others to administer Autism Spectrum Disorder (ASD) and other Developmental Disability (DD) services and benefits.

Beacon's Autism Services network is composed of Board Certified Behavior Analysts (BCBA), Board Certified Assistant Behavioral Analysts (BCaBA), ABA paraprofessionals and other clinicians. Their mission is to deliver comprehensive assessments and Applied Behavior Analysis (ABA) therapy that is consistent, effective, and evidence-based. The aim is to bridge the gap, as early and rapidly as possible, between the person's chronological age and their developmental age and enable mainstream adjustment to the extent achievable.

The company arranges access for members of contracted health plans to its network of BCBA, BCaBA and ABA paraprofessionals and other clinicians then in turn, our Beacon Care Coordinators assure coordination of care with parents and all treating professionals.

### OUR MISSION

Beacon Autism Services division was created to seamlessly integrate systems of clinical and administrative autism resources that will deliver accountable, family-sensitive, outcome-focused care.

### OUR CLINICAL FOCUS

This Policy and Procedures Manual states how the mission is to be realized, parameters to be observed, and the delegation of authority for implementation of the policies and procedures. We expect our network participants to become familiar with all aspects of this manual.

Beacon believes we are engaged in a partnership with our network providers, and the basis of this partnership is mutual benefit between Beacon, our providers and the members we serve. We strongly encourage dialogue, and are open to your ideas.

Thank you for participating.

Chapter 2

# Provider Participation in Beacon's Behavioral Health Services Network

## 2.1. Network Provider Participation

Beacon is responsible for maintaining an adequate range of providers for the membership we cover. Therefore, we offer a network consisting of qualified professionals such as: Board Certified Behavior Analysts (BCBA), Board Certified Assistant Behavioral Analysts (BCaBA), ABA Para-professionals and other Clinicians who represent an array of clinical and cultural specialties. This allows us to meet the clinical, cultural, and geographical needs of our members.

### NON DISCRIMINATION

Beacon does not deny or limit the participation of any clinician or agency in the network, and/or otherwise discriminate against any clinician or agency based solely on any characteristic protected under state or federal discrimination laws.

Furthermore, Beacon has never had a policy of terminating any clinician or agency because the clinician or agency representative:

- Advocated on behalf of a member
- Filed a complaint against a health plan
- Appealed a decision of Beacon
- Requested a review of a termination decision or challenged a termination decision of Beacon.

Nothing in the Participation Agreement should be read to contradict, or in any way modify, this long-standing policy and practice of Beacon.

## 2.2. Beacon Dedication

Beacon is dedicated to selecting qualified behavioral health care professionals, groups and facilities to provide member care and treatment for our members.

### OUR POLICY

To be an in-network provider with Beacon Autism Services, you must be both credentialed and contracted. Depending on your credentials and our client requirements, you may be eligible to provide services to our members. We ask that all our network providers:

- Follow the policies and procedures outlined in this Provider Manual, as well as any applicable supplements and your provider participation agreement(s)
- Provide medically necessary covered services to members whose care is managed by Beacon
- Provide services in accordance with applicable state and federal laws and licensing and certification bodies
- Agree to cooperate and participate with all utilization management, quality improvement, outcomes measurement, peer review, and appeal and grievance procedures

### WHAT BEACON WILL DO

- Maintain a credentialing and recredentialing process to evaluate and select network providers that does not discriminate based on a member's benefit plan coverage, race, color, creed, religion,

gender, sexual orientation, marital status, age, national origin, ancestry, citizenship, physical disability, or any other status protected by applicable law

- Appoint high level individuals to be responsible for implementation and oversight of the Compliance Program
- Develop and implement training programs on compliance and risk management to ensure that our providers understand how to be compliant with regulation and law as it affects their work
- Develop monitoring/auditing systems that help detect non-compliance and wrong doing and that give our providers the ability to report questionable conduct

## 2.3. Network Adequacy

Beacon Autism Services is committed to providing services to families and individuals diagnosed with ASD. Beacon follows health plan requirements and state regulations in ensuring that the ABA network is adequate.

### WHAT BEACON WILL DO

- Recruit providers in potential geographical areas of need that may arise in the network
- Continue to leverage the tiered service delivery model recommended by the Behavior Analysis Certification Board (BACB)

## 2.4. Waiting List and Appointment Availability

Beacon holds its providers and member to the highest standards. The expectation for providers to provide availability of clinical appointments for members is crucial.

### OUR POLICY

Beacon members are not to be placed on a waiting list as Providers are required to maintain hours sufficient to meet the demands of the practice. For new referrals, you may request to be listed in our database as unavailable at one or more of your practice locations for up to six months. Provider may limit acceptance of members, who are not already patients of provider, as patients only if the same limitations apply to all other potential new patients of the provider. You are required to notify network management within 10 calendar days of your lack of availability for new referrals.

In order to be in compliance with this policy, if a provider is no longer available to provide services for new members the following steps are **mandatory**:

- Inform the member to contact their Beacon Autism Services Care Coordinator- the member has the option to wait for that provider for the next available appointment; however this must be clearly documented
- Contact a Beacon Autism Services Care Coordinator and inform them of the situation and have it documented in writing either via electronic copy or hard copy

### WHAT BEACON WILL DO

- Document and file your letter and begin actively searching for a new provider to take on the member
- Inform the provider of when the member will be officially discharged from their program

- Collect all needed relevant files and information surrounding the case
- Inform the provider of the last day they will be entering in services into the software

## 2.5. Credentialing

As part of the credentialing process, clinicians and/or agencies are required to submit documentation supporting their professional and community standing and defining their program offerings.

You will be asked to sign a release of information granting Beacon access to information pertaining to your professional standing. This requirement for primary source verification is necessary to complete the credentialing process. Failure to provide such release will adversely affect your ability to participate in the network. In addition, failure to meet Beacon standards of submitted records will prohibit participating in the network.

Only clinicians credentialed through Beacon are considered network clinicians. Contracting with a group does not guarantee that all clinicians in the practice are credentialed.

### OUR POLICY:

Beacon is committed to promoting quality care for its members. In support of this commitment, clinicians must meet a minimum set of credentialing criteria in order to be able to provide services to our membership.

Our Network Development Specialists are the primary source for credentialing requirements and obtaining provider network referral status. We credential providers in accordance with our credentialing criteria and in accordance with specific criteria required by applicable regulatory agencies and/or client companies. This documentation includes (but is not limited to):

- A completed credentialing application
- Copies of current licenses and certifications as applicable
- Documentation of education, training, and work history (Work history must include the job titles, from the last five years using a month/year format. Any gaps in work history greater than six months must be explained in writing.)
- Completed W-9 form, with taxpayer identification number (TIN) signed and dated
- Copies of professional and general liability insurance policies
- Signed attestation agreement
- Signed Beacon provider attestation letter
- Signed disclosure/authorization form
- Completed background check within the last 60 days

An ABA therapist or paraprofessional will be asked to additionally submit:

- An education attestation agreement signed by the organization or a supervisor

### WHAT BEACON WILL DO

As an applicant to our network, Beacon will:

- Notify you if any required information is missing from your credentialing application

- Process all applications within 180 days or in accordance with applicable state or client company guidelines
- Present your application to the Credentialing Committee for review once the credentialing verification process is complete
- Review your credentialing information, including, but not limited to: training, experience and specialty areas, along with member need and access, subject to applicable state laws and
- Make determinations regarding provider participation in Beacon's provider networks
- Notify you when the credentialing process is complete

## 2.6. Recredentialing

As part of the recredentialing process, clinicians and agencies are required to have their credentials re-reviewed periodically through the recredentialing process. Individual professional provider recredentialing is conducted every three years unless otherwise required by applicable state and federal law, a customer and/or an accrediting entity.

The documentation for recredentialing includes (but is not limited to):

- A completed recredentialing application
- Copies of current licenses and certifications as applicable
- Documentation of education, training, and work history (with the same conditions as in the credentialing process)
- Completed W-9 form, with taxpayer identification number (TIN), signed and dated
- Copies of professional and general liability insurance policies
- Signed attestation agreement
- Signed Beacon provider attestation letter
- Signed disclosure/authorization form
- Completed background check within the last 60 days

### WHAT BEACON WILL DO

- Provide you with ample notice of the recredentialing process
- Provide you with a recredentialing application and instructions for completing and submitting the application
- Review the materials you submit in a timely manner
- Inform you of the outcome of your recredentialing review

## 2.7. Written Notification of Status Changes for Clinicians or Practice Locations

We are committed to maintaining current and accurate provider practice information in our database in order to refer members to qualified providers and enable providers to receive important communications from Beacon in a timely manner.

### OUR POLICY

Beacon policy is to update our databases in a timely manner with accurate information from our providers to facilitate efficient and effective referral and claims processing, and to provide accurate and timely information in provider-related publications. In order to maintain our commitment to updated and accurate information provider shall provide notice to IPA and payor as applicable in writing, 90 days prior to a planned change or as soon as provider becomes aware of an unplanned change:

- The status of the practice, including changes in practice location, billing address, business hours, email addresses and/or telephone or fax number(s), as well as changes in practice ownership
- The status of professional licensure and/or certification such as revocation, suspension, restriction, probation, termination, reprimand, inactive status, voluntary relinquishment, of any other adverse action
- The status of professional liability insurance
- Potential legal standing (any malpractice action or notice of licensing board complaint filing)
- The tax identification number (TIN) used for claims filing
- The programs you offer (services you provide must continue to meet our credentialing criteria)

Changes must be submitted in writing, via mail or fax, to Provider.Inquiry@beaconhealthoptions.com.

### WHAT BEACON WILL DO

- Update your provider record promptly
- Contact you for clarification, if needed

## 2.8. Infection Control

Beacon recognizes that contracted employees may be working with clients who have a higher than average risk of carrying particular diseases and infections. Because of this, procedures must be in place to help protect providers and clients by containing the spread of a communicable disease in community programs and within the community at large.

### OUR POLICY

Should a provider or Beacon be notified of client infection including but not limited to: vomiting, diarrhea, fever and/or frequent sneezing or coughing, or other flu-like symptoms, they are instructed to cancel clinical treatment appointments.

Conversely, should a provider him or herself become ill with infection, it is Beacon's expectation that the provider will cancel clinical treatment appointments and resume services only after medical clearance determines they are no longer infectious to others.

As a provider in our network, it is your responsibility to:

- Call the parent/guardian and cancel the clinical treatment appointment and explain why.
- If the infection has not gone away for over a week, notify Beacon as to why you have not been rendering services.

### WHAT BEACON WILL DO

- Make a note in the file. If any other directions are needed/ required we will reach out to you.

Chapter 3

# Members Rights and Responsibilities

## 3.1. Member Rights and Responsibilities

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

**Beacon members have the right to:**

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

**Beacon members have the role to:**

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

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

### 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 demographic of the population(s) served. This statement can either be Beacon's statement or a comparable statement consistent with the provider's state license requirements.

### INFORMING MEMBERS OF THEIR RIGHTS AND RESPONSIBILITIES

Providers are responsible for informing members of their rights and respecting these rights. In addition to a posted statement of member's 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

## 3.2. Non-Discrimination Policy and Regulations

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

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

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

## 3.3. 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 health care operations at the sign-up for health insurance. Treatment, payment and health care operations involve a number of different activities, including but not limited to:

- Submission and payment of claims
- Seeking authorization for extended treatment

- QI initiatives, including information regarding 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.

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 or legal guardian'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.

Chapter 4

# Quality Management and Improvement Program

## 4.1. Quality Management & Improvement Program Overview

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

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

### QUALITY MANAGEMENT PROGRAM OVERVIEW

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

The scope of the Corporate QMP includes:

a. Clinical services and Utilization Management Programs

b. Supporting improvement of continuity and coordination of care

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

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

e. Outcome Measurement and data analysis

f. Network Management/Provider Relations Activities

g. Member Experience Survey

h. Clinical Treatment Record Evaluation

i. Service Availability and Access to Care

j. Practitioner and Provider Quality Performance

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

l. Member Rights and Responsibilities

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

n. Clinical and Administrative Denials and Appeals

o. Performance Indicator development and monitoring activities

p. Health Literacy and Cultural Competency assurance

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

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

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

t. Screening Programs

u. Complaints and Grievances

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

## 4.2. Role of Participating Providers

Participating practitioners/providers are informed about the QMP via the Beacon Provider Handbook, provider newsletters, website information, direct mailings, email provider alerts, seminars and training programs. Many of these media venues provide network practitioners/providers with the opportunity to be involved and provide input into the QM and UM Programs. Additional opportunities to be involved include representation on the National Credentialing and Provider Appeals Sub-Committees as well as on various committees and sub-committees and/or workgroups at the Regional or Engagement Center level (e.g., Credentialing Committee and Clinical Advisory Committees). Involvement includes, but is not limited to:

- Providing input into the Beacon medical necessity criteria
- Providing peer review and feedback on proposed practice guidelines, clinical quality monitors and indicators, new technology and any critical issues regarding policies and procedures of Beacon
- Reviewing QIAs and making recommendations to improve quality of clinical care and services
- Reviewing, evaluating, and making recommendations for the credentialing and re-credentialing of participating practitioners and organizational providers
- Reviewing, evaluating and making recommendations regarding sanctions that result from participating practitioner and organizational provider performance issues

As part of the QMP, Beacon incorporates principles designed to encourage the provision of care and treatment in a culturally competent and sensitive manner. These principles include:

- Emphasis on the importance of culture and diversity
- Assessment of cross-cultural relations
- Expansion of cultural knowledge
- Consideration of sex and gender identity
- Adaptation of services to meet the specific cultural and linguistic needs of members.

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

### PROVIDER ROLE BEFORE SERVICES BEGIN

When members contact Beacon Autism Services for a referral, our philosophy is to refer them to clinicians who best fit their needs and preferences taking into account factors including provider geography, accessibility, availability (number of BCBAs and ABA Therapists), and specialization.

#### Our Policy

Beacon policy is to refer members to providers who best fit their needs and preferences based on member information shared with Beacon at the time of intake.

As a provider who has received a call from a member with commercial insurance seeking ABA services we request that you:

- Instruct the parent or guardian to call the Beacon Autism Services call center to speak with a Care Coordinator to discuss accessing their benefits.

#### What Beacon Will Do

- Reach out to the insurance company for eligibility and an authorization determination based upon the information provided by the member
- Send the member referral back to you, the provider
- Communicate the type of service(s), number of sessions or days authorized, and a start- and end-date for authorized services from the insurance company's authorization determination; by telephone, online and/or in writing to you as required by regulation and/or contract

## 4.3. Quality Performance Indicator Development and Monitoring Activities

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

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

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

- Access and availability to behavioral health services
- Telephone service factors
- Utilization decision timeliness, adherence to medical necessity, and regulatory requirements
- Member and provider complaints and grievances

- Member and provider satisfaction with program services
- Nationally recognized or locally prescribed care outcome indicators such as HEDIS measures whenever possible
- Potential member safety concerns, which are addressed in the Member Safety Program section of this handbook, include
    - Serious reportable events (SREs) as defined by the National Quality Forum (NQF) and Beacon, and
    - Trending Events (TEs)

## 4.4. Member Safety Program

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

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

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

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

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

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

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

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

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

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

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

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

- Provider inappropriate/unprofessional behavior
  - Inappropriate boundaries/relationship with member
  - Practitioner not qualified to perform services
  - Aggressive behavior
  - Displays signs of cognitive, mental health, or substance use concerns impacting the care being provided
- Clinical practice-related issues
  - Abandoned member or inadequate discharge planning
  - Timeliness, accuracy, or adequacy of diagnosis, assessment, or referral
  - Delay in treatment
  - Effectiveness of treatment
  - Failure to coordinate care or follow clinical practice guidelines
  - Failure to involve family in treatment when appropriate
  - Medication error or reaction
  - Treatment setting not safe
- Access to care-related issues
  - Failure to provide appropriate appointment access
  - Lack of timely response to telephone calls
  - Prolonged in-office wait time or failure to keep appointment
  - Provider non-compliant with American Disabilities Act (ADA) requirements
  - Services not available or session too short
- Attitude and service-related issues
  - Failure to allow site visit
  - Failure to maintain confidentiality
  - Failure to release medical records
  - Fraud and abuse
  - Lack of caring/concern or poor communication skills
  - Poor or lack of documentation
  - Provider/staff rude or inappropriate attitude
- Other monitored events
  - Adverse reaction to treatment
  - Failure to have or follow communicable disease protocols
  - Human rights violations
  - Ingestion of an unauthorized substance in a treatment setting
  - Non-serious injuries (including falls)
  - Property damage and/or fire setting
  - Sexual behavior

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

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

## 4.5. Confidentiality

All information in the member's service record, and other information acquired in the course of providing autism spectrum disorder services shall be kept confidential and shall not be open to public inspection.

### OUR POLICY

Beacon protects access to protected health information (PHI) in the following ways:

- Utilizing strict guidelines for how member information may be used and disclosed
- Requiring all employees to be familiar with the process for responding to any unauthorized uses or disclosures of confidential member information
- Making sure that the *Authorization to Use or Disclose Protected Health Information Form* we use complies with applicable state and federal laws and client-specific requirements
- Monitoring provider adherence to privacy policies and procedures through quality reviews and routine contact
- Monitoring member feedback through the complaint process
- Complying with applicable state and federal laws and accrediting organization standards
- Establishing proper mechanisms for timely and appropriate responses to member rights issues, including but not limited to member requests for confidential communications, access to PHI, amendments to PHI, and accounting of disclosures
- Implementing technical barriers to systems by requiring authorization and passwords to access systems containing confidential information
- Requiring the minimum necessary information for routine uses and disclosures of health information

As a provider in our network it is imperative that you:

- Comply with applicable state and federal laws and regulations that address member privacy and confidentiality of PHI
- Utilize HIPAA-compliant authorization forms and consent for treatment forms that comply with applicable state and federal laws
- Maintain member's signed release of information (ROI) for the clinical record
- In the event a member declines to consent to ROI, his or her refusal should be documented along with reason for refusal
- Use only secure email (secure messaging) when requesting member PHI
- Establish office procedures regarding communication with members (e.g., telephone and cell phone use, and written, fax and Internet communication)
- Establish a process that allows members access to their records in a confidential manner

### WHAT BEACON WILL DO

- Collaborate with you to protect member privacy and confidentiality
- Request the minimum necessary protected health information to perform needed health care operations, utilization review and payment activities

- Only respond to electronic (Internet) requests for PHI through secure email channels

## 4.6 Treatment Record Standards and Guidelines

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

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

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

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

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

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

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

## 4.7. Treatment Record Reviews

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

Beacon may conduct treatment record reviews and/or audits:

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

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

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

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

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

## 4.8. Treatment Plan Discharge

Effective discharge planning addresses how a member's needs will be met during transition from one level of care to another or to a different treating clinician. This planning begins with the onset of care and should be documented and reviewed over the course of care. Treatment planning will focus on achieving and maintaining a desirable level of functioning after the completion of the current episode of care. Effective treatment and discharge planning is a key indicator of the ongoing health and well-being of a member following acute care.

Care Coordinators will work with you to begin the discharge or treatment planning process for members at the time that services are initiated. As appropriate, the discharge or treatment planning process will involve you, a Care Coordinator, the member, the member's family and/or representative. Discharge planning involves assessment of the member's needs including current functioning, resources, and barriers to treatment access or compliance. Member and family participation in and agreement with treatment and discharge planning should be well documented in the clinical record. A 60-day notice in writing is needed if discharging a case that still requires care.

### UNPLANNED DISCHARGE

Beacon recognizes that there may be instances where treatment terminates unexpectedly through no fault of the provider or member.

#### Our Policy

It is Beacon's policy that providers do the following:

- Notify a Beacon Autism Services Care Coordinator of the discharge as well as the reason for such
- Have prepared an assessment of the member's needs including current functioning, resources, and barriers to treatment access or compliance
- Have prepared a viable and actionable aftercare plan for the member in the interest of quality and continuity of care

**Please note:** If a member discontinues treatment but returns at a later time, this should be considered a new episode of care and require a new intake at that time.

## 4.9. Inquiry and Review Process

Beacon is committed to developing and maintaining a high-quality provider network.

### OUR POLICY

Beacon maintains a process for inquiry, review and action when concerns regarding provider performance are identified.

As a provider with Beacon your responsibility is to:

- Actively participate and cooperate with the investigation and resolution of any identified concerns as a condition of continued participation in the Beacon provider network
- Inform members that they have a right to file a complaint directly with Beacon or their healthcare plan

### WHAT BEACON WILL DO

- Contact you by phone or in writing to inquire about the nature of the concern and request additional information if a concern regarding quality of care or service is raised
- Review all inquiries for adequate resolution of any performance concerns
- Advise you when a corrective action plan and follow-up are required
- Advise you of a change in the conditions of your network participation, if determined to be required
- Advise you, in writing, if any action is taken as a result of the inquiry and review process

## 4.10. Fraud, Waste, and Abuse

Beacon seeks to provide and manage a system of autism spectrum disorder services that is free of purposeful deception or misrepresentation by a network provider to gain an unauthorized benefit and no activities committed by a network provider that are inconsistent with standard fiscal, business, or medical practices and result in unnecessary cost to a health care, or that fail to meet professionally recognized standards for health care.

### OUR POLICY

Beacon does not tolerate fraud, waste or abuse, either by providers or staff. Accordingly, we have instituted extensive fraud, waste and abuse programs to combat these problems. Beacon's programs are wide-ranging and multi-faceted, focusing on prevention, detection and investigation of all types of fraud, waste and abuse in government programs and private insurance.

Provider fraud and abuse can include: Physical/verbal abuse to a member, financial abuse of the Beacon system in over treating a member with unnecessary services, denial of care, confidentiality violations, fraudulent billing, provider staff misrepresenting credentials, as well as any other provider action that places a member in jeopardy or violates federal/state or other applicable regulations.

In order to assure that our providers comply will all laws and Beacon requirements, we require that providers follow these guidelines:

- Ensure that the claims that you (or your staff or agent) submit and the services you provide do not amount to fraud, waste or abuse and do not violate any federal or state law relating to fraud, waste or abuse. Ensure that you provide services to members that are medically necessary and consistent with all applicable requirements, policies and procedures
- Comply with all federal and state laws regarding fraud, waste and abuse
- Provide and bill only for medically necessary services that are delivered to members in accordance with Beacon's policies and procedures and applicable regulations
- Ensure that all claims submissions are accurate
- Notify Beacon immediately of any suspension, revocation, condition, limitation, qualification or other restriction on your license, or upon initiation of any investigation or action that could reasonably lead to a restriction on your license, or the loss of any certification or permit by any federal authority, or by any state in which you are authorized to provide health care services;
- Cooperate with Beacon's investigations. Our expectation is that you will fully cooperate and participate with its fraud, waste and abuse programs. This includes, but is not limited to, permitting Beacon access to member treatment records and allowing Beacon to conduct audits or reviews. Beacon also may interview members as part of an investigation, without provider interference; and
- Report Suspected Fraud, Waste or Abuse
    - Beacon expects that its providers and their staff and agents to report any suspected cases of fraud, waste or abuse. Beacon will not retaliate against you if you inform us, the federal government, state government or any other regulatory agency with oversight authority of any suspected cases of fraud, waste or abuse.

## UNDERSTANDING FRAUD, WASTE, AND ABUSE

**Fraud** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

**Abuse** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to government-sponsored programs, and other health care programs/plans, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to federally and/or state-funded health care programs, and other payers.

**Waste** means over-utilization of services or other practices that result in unnecessary costs.

Some examples of fraud, waste, and abuse include (but are not limited to):

- Billing for services or procedures that have not been performed or have been performed by others
- Submitting false or misleading information about services performed
- Misrepresenting the services performed (e.g., up-coding to increase reimbursement)
- Retaining and failing to refund and report overpayments
- A claim that includes items or services resulting from a violation of the Anti-Kickback Statute now constitutes a false or fraudulent claim under the False Claims Act

- Routinely waving patient deductibles or co-payments
- An individual provider billing multiple codes on the same day where the procedure is mutually exclusive of another code billed on the same day
- Treating all patients weekly regardless of medically necessity
- Routinely maxing out of members' benefits or authorizations regardless of whether or not the services are medically necessary
- Inserting a diagnosis code not obtained from a physician or other authorized individual
- Submitting claims for services ordered by a provider that has been excluded from participating in federally and/or state-funded health care programs
- Misrepresenting credentials, such as degree and licensure information

### WHAT BEACON WILL DO

Implement and regularly conduct fraud, waste and abuse prevention activities that include:

- Extensively monitoring and auditing provider utilization and claims to detect fraud, waste, and abuse
- Actively investigating and pursuing fraud and abuse and other alleged illegal, unethical or unprofessional conduct
- Reporting suspected fraud, waste and abuse and related data to federal and state agencies, in compliance with applicable federal and state regulations and contractual obligations
- Cooperating with law enforcement authorities in the prosecution of health care and insurance fraud cases
- Verifying eligibility for members and providers
- Making the Beacon Autism Services Provider Manual available to network providers

## 4.11. Federal False Claims Act

According to federal and state law, any provider who knowingly and willfully participates in any offense as a principle, 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 and liability on any person who knowingly:

1. Presents (or causes to be presented) to the federal government a false or fraudulent claim for payment or approval
2. Uses (or causes to be used) a false record or statement to get a claim paid by the federal government
3. Conspires with others to get a false or fraudulent claim paid by the federal government

4. Uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money or transmit property to the federal government

### Penalties

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

### *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 compliant. 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 his or her employer. The employer 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 the submit the findings that involve more serious problems than just simple errors to the agency.

If any member or provider becomes aware of any potential fraud by a member or provider, please contact us at 855.834.5654 and ask to speak to the Compliance Officer.

## 4.12. Contract Termination

The participation of a clinician or an agency with Beacon can end for a variety of reasons. Both parties have the right to terminate the contract with Beacon upon written notice.

### OUR POLICY

Network providers may be terminated from the networks of Beacon and/or its affiliated companies for the following reasons, including, but not limited to:

- Failure to submit materials for recredentialing within required timeframes
- Suspension, loss or other state board actions on licensure
- Provider exclusion from participation in federally or state-funded health care programs
- Quality of care or quality of service concerns as determined by Beacon
- Failure to meet or maintain Beacon's recredentialing criteria
- Provider-initiated termination
- No current business need within the provider's geographic area, subject to applicable state and federal law

In order to adhere to our high quality standard of network of providers your responsibility is to:

- Advocate on behalf of members
- Maintain your professional licensure in a full, active status
- Respond in a timely manner to recredentialing requests
- Follow contract requirements, policies, and guidelines including appropriate transition of members in care at the time of contract termination

It is important to note network providers will not be terminated from the networks of Beacon, and/or its affiliated companies for any of the following reasons:

- Provider advocating on behalf of a member
- Provider filing a complaint against Beacon
- Provider appealing a decision of Beacon
- Provider requesting a review of or challenging a termination decision of Beacon

### WHAT BEACON WILL DO

- Respect your right to advocate on behalf of members
- Not terminate your contract for advocating on behalf of members, filing a complaint, appealing a decision, or requesting a review of or challenging a termination decision of Beacon
- Notify you when recredentialing materials must be submitted and monitor your compliance
- Communicate quality concerns and complaints received from members
- Notify you of the reason for contract termination and your appeal rights, as applicable, if your contract is terminated

## 4.13. Complaints and Grievances

As members of our network, providers have a specific process for filing grievances and complaints and having those grievances and complaints addressed and resolved.

### OUR POLICY

Providers with complaints or concerns should contact the appropriate Beacon service center at the number provided below and ask to speak with a Beacon Autism Services Care Coordinator. All provider complaints are thoroughly researched by Beacon and resolutions proposed within 20 business days.

Cypress Beacon Autism Services 855.834.5654

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, he or she should be directed to call Beacon's Ombudsperson at 855.834.5654 (or TTY at 866.727.9441).

A **complaint** 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 complaints 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.

A **grievance** is any formally documented expression of dissatisfaction by a provider.

### WHAT BEACON WILL DO

- Work to resolve the matter, if possible, within three business days
- Conduct an internal investigation if the matter is not resolved within three business days
- Document the complaint or grievance in the appropriate log or report form and track for monitoring and trending purposes
- Contact the provider directly with an advised resolution. If the resolution is not satisfactory to the provider, the provider has rights to elevate the issue further to the QI department for further investigation and immediate resolution

## 4.14. Appealing Decisions

Providers have the right to appeal Beacon's quality review actions that are based on issues of quality of care or service that impact the conditions of the provider's participation in the network.

### OUR POLICY

Client requirements and applicable federal and state laws may impact the appeals process; therefore, the process for appealing is outlined in the letter notifying a provider of changes in the conditions of their participation due to issues of quality of care or services.

As a provider with Beacon your responsibility is to submit a written request to the Beacon Quality Manager within 30 calendar days of disposition. The request must include the reason for dispute, justification for the appeal, and documentation to support the appeal.

### WHAT BEACON WILL DO

- Provide you with your rights to appeal an adverse decision
- Grant you the opportunity to have a fair hearing

Chapter 5

# Case Management and Utilization Management

## 5.1. Case Management

Beacon is committed to delivering high-quality, cost-effective health care in a manner that improves the health and quality of life of our members diagnosed with an Autism Spectrum Disorder (ASD). Beacon requires the highest standard of professional performance from its providers and support staff.

### OUR POLICY

Provider performance management will be implemented to ensure contractual obligations and best practice service delivery is met between Beacon and its contacted providers. Performance-based provider management involves various activities such as, but not limited to:

- Gathering clinical data and member's data regarding their quality of service experience
- Measurement of the level of the provider's contractual collaboration, and member case information
- Analysis of claims data to verify that claim submissions accurately represent the services provided to members, as well as to ensure that billing is conducted in accordance with guidelines and other applicable standards, rules, laws, regulations, contract provisions, and payment policies

### WHAT BEACON WILL DO

Beacon will conduct audits and research complaints. The purpose on an audit is to validate accuracy of billing/payment, confirm claims accurately represent the services provided to members, and both quality of care and service provided to plan members reflects appropriate clinical care. Audits may include but are not limited to:

- Random selection of finalized claims to determine payment and financial accuracy
- Issue-specific situations, such as the discovery of duplicate payments or high dollar claims
- Ad-hoc or targeted issue
- On-site review

Further details about Provider Performance Management and Audit Scope can be found in Appendix A.

### MANUAL UPDATES AND GOVERNING LAWS

This manual is updated periodically as procedures are modified and enhanced. You will be notified a minimum of 30 calendar days prior to any material change to the manual unless otherwise required by regulatory or accreditation bodies.

This manual shall be governed by, and construed in accordance with, applicable federal, state, and local laws.

## 5.2. Utilization Management

Utilization Management (UM) is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or effectiveness 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, case management, discharge planning, and retrospective review.

Beacon's UM program is administered by 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 Beacon's level of care criteria (medical necessity)
- Financial incentives based on an individual UM clinician's number of adverse determinations or denials of payment are prohibited
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization

Note that the information in this chapter, including definitions, procedures, and determinations and notification timelines may vary for different lines of business, based on differing regulatory requirements.

## 5.3. Medical Necessity

All requests for authorization are reviewed by Beacon clinicians based on the information provided, according to the following definition of medical necessity:

Medically necessary services are healthcare and services that are:

1. Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (most current version of ICD or DSM,) that threatens life, causes pain or suffering, or results in illness or infirmity
2. Expected to improve an individual's condition or level of functioning
3. Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs
4. Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications
5. Reflective of a level of service that is safe, where no equally effective, more conservative, and less resource intensive treatment is available
6. Not primarily intended for the convenience of the recipient, caretaker, or provider
7. No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency
8. Not a substitute for non-treatment services addressing environmental factors

This definition applies to all levels of care and instances of Beacon's utilization review.

## 5.4. Level of Care Criteria

Beacon's level of care criteria (LOCC) are the basis for all medical necessity determinations. Providers can contact us to receive a printed copy of Beacon's LOCC.

Beacon's LOCC were developed from the comparison of national, scientific and evidence-based criteria sets, including but not limited to, those publicly disseminated by the American Medical Association (AMA), the American Psychiatric Association (APA) and the Behavior Analysis Certification Board (BACB). They are reviewed and updated annually or more often, as needed, to incorporate new treatment applications and technologies adopted as generally accepted professional medical practice. Beacon's Research and

Development Committee reviews all new treatment applications and technologies and then presents the information to the Provider Advisory Council for review and recommendations.

Beacon's LOCC 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.

## 5.5. Utilization Management Terms and Definitions

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

**UM TERMS AND DEFINITIONS**

| TERM | DEFINITION |
|---|---|
| **Adverse Determinations** | A determination to deny, terminate or modify (an approval of fewer days, units or another level of are other than was requested, which the practitioner does not agree with) an admission, or the availability of any other behavioral health care service, for:<br>a. Failure to meet the requirements for coverage based on medical necessity<br>b. Appropriateness of health care setting and level-of-care effectiveness<br>c. Health Plan benefits |
| **Adverse Action** | The following actions or inactions by Beacon or the provider organization:<br>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<br>2. Beacon's denial or limited authorization of a requested service, including the determination that a requested service, is not a covered service<br>3. Beacon's reduction, suspension, or termination of a previous authorization for a service<br>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:<br>a. Failure to follow prior authorization procedures<br>b. Failure to follow referral rules<br>c. Failure to file a timely claim<br>5. Beacon's failure to act within the timeframes for making authorization decisions |

| TERM | DEFINITION |
| --- | --- |
| | 6. Beacon's failure to act within the timeframes for making appeal decisions. |
| **Non-Urgent Concurrent Review and 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 number of days or treatments, or deny requested treatment, in a non-acute treatment setting. |
| **Non-Urgent Pre-Service Review and 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 non-acute treatment setting. |

Chapter 6

# Clinical Reconsiderations and Appeals

## 6.1. Provider Claim Dispute Resolutions

### CLAIMS INQUIRY DEFINITION

A claims inquiry is when a provider calls to check the status on a claim and/or reimbursement. The inquiry is resolved over the phone with agreed-upon follow-up actions.

### CLAIMS DISPUTE DEFINITION

A claims dispute is when a provider disagrees with the follow-up actions determined during the inquiry. Claims disputes must be submitted in writing. Each contracted provider dispute must contain, at a minimum, the following information: provider's name, billing provider's tax ID number or Beacon Autism Service's provider ID number, provider's contact information, and:

1. If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from Beacon to a contracted provider, the following must be provided: original claim form number (located on the remittance advice), a clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contents, denial, adjustment, or other action is incorrect.
2. If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue must be provided.
3. If the contracted provider dispute involves a patient or group of patients, the name and identification number(s) of the patient or patients, a clear explanation of the disputed item, including the date of service and provider's position on the dispute, and a patient's written registration for provider to represent said patients must be provided.

### TIMEFRAMES

- Providers must submit claims within 60 days of the date of service. For Medi-Cal lines of business, please contact Provider Relations for information on the health plan-specific timely filing limit.
- Providers have up to 365 calendar dates after the date of determination to submit a *Claims Dispute Resolution Form*.
- Provider must receive notification of receipt of *Claims Dispute Resolution Form* from Beacon within 15 working days from date of receipt.
- Behavioral Health Network, Inc. has 45 working days from date of receipt to issue a determination regarding the dispute.
- Once a determination has been made, Behavioral Health Network, Inc. has five working days to notify provider and/or issue a payment of claims.

## 6.2. Clinical Appeal Process

It is the policy of Beacon to offer members, their Authorized Member Representatives/designees (AMR) and providers the opportunity to appeal an adverse determination during the utilization review (UR) process; this policy also applies to administrative adverse actions for which Notice of Action is required by state regulations. 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.

All medical necessity appeals are conducted by a Beacon physician/psychologist advisor (Beacon PA) who was not the physician/psychologist that made the original adverse determination, nor subordinate of that physician/psychologist. Note: Psychologists may deny outpatient services only. The Beacon PA conducting the appeal must be actively practicing and hold an active, unrestricted license to practice psychiatry/psychology, (the same license status as the ordering practitioner) in the same or similar specialty with experience treating or managing the medical condition, procedure or treatment under review.

## 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.

If a plan member or a member's provider disagrees with a utilization review decision issues 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 PA 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.

## URGENCY OF APPEAL PROCESSING

Appeals can be processed on a standard or an expedited basis, depending on the urgency of the need for 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 complete and return a signed and dated *Clinical Formal Appeal Form* prior to Beacon's deadline for resolving the appeal. A copy of the form can be obtained by calling 855.834.5654. 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.

## APPEAL PROCEDURES

1. If a Beacon PA determines that requested services are not medically necessary, and the PA and attending provider are unable to negotiate a mutually acceptable plan, the Beacon PA will issue an adverse determination. Notifications of adverse actions include the procedure for initiating an appeal and are communicated to enrollees. AMRs, attending providers and/or health care facilities.

2. If an adverse action is made by Beacon and the attending behavioral health provider believes that the determination warrants an immediate reconsideration, Beacon shall provide the opportunity to seek a reconsideration of that determination by telephone with the Beacon PA who made the review determination (if the Beacon PA is not available then another Beacon PA will be assigned). The reconsideration must be completed within one business day of the receipt of request.
3. Any party whose adverse action is not resolved through the reconsideration process shall be offered the opportunity to appeal the decision through the formal internal appeal process.
4. An appeal must be filed within 60 business days of receipt of notification of Beacon's adverse determination. Members are offered the right of representation throughout the appeals process and the opportunity to submit written comments and documents concerning he appeal to the appeals coordinator. Additionally, members are informed that they may have access to, and copies of, documents relevant to the appeal, upon request.
5. After an appeal is submitted by telephone or in writing, a Beacon appeals coordinator sends out corresponding acknowledgement letters to the enrollee, AMR and/or provider. Acknowledgement letters for standard (non-urgent) appeals are sent within five days of the receipt of appeal request, acknowledging receipt of the appeal and notification that a determination will be made within 30 calendar days.
6. Determination and notification of appeal decisions are communicated to the enrollee, AMR or provider, as appropriate, within the timeframes listed in tables below, depending on the nature of the request and the urgency of the case.

Decision and notification timeframes are summarized in the tables below. Note that all appeal timeframes start from the time of the request by the member, AMR, or provider:

**PRE-SERVICE TIME TO DECISION AND NOTIFICATION**

| REVIEW TYPE | RECONSIDERATION | LEVEL 1 APPEAL* |
|---|---|---|
| Urgent/Expedited | 1 business day | 2 business days, no more than 72 hours |
| Non-Urgent/Standard | 1 business day | 30 calendar days |

**CONCURRENT REVIEW TIME TO DECISION AND NOTIFICATION**

| REVIEW TYPE | RECONSIDERATION | LEVEL 1 APPEAL* |
|---|---|---|
| Urgent/Expedited | 1 business day | 2 business days, no more than 72 hours |
| Non-Urgent/Standard | Not applicable | Not applicable |

** The outcome of a Level 1 standard appeal is considered a Final Adverse Determination (FAD); if the Level 1 appeal is expedited, a Level 2 standard appeal may be requested.*

Resolution and notification (written and verbal) of pre-service and concurrent appeals (expedited) will be completed within two business days of receipt of all necessary information and no later than 72 hours of

the date of receipt of the appeal, or as expeditiously as the member's condition requires. Beacon does not send acknowledgement letters for urgent (expedited) appeals.

Resolution of non-urgent (standard) pre-service appeals will occur within 30 calendar days of receipt of request. The notification of the determination will be sent within two business days of the resolution.

Timeframes for resolution of an appeal can be extended by 14 days if the enrollee or his or her designee requests an extension verbally or in writing. Beacon can initiate and extension of the timeframes for appeal resolution by 14 days if it can be substantiated that there is a need for additional information, and the extension is in the best interest of the member. Beacon will maintain sufficient documentation of extension determinations to demonstrate that the extension was justified. Notification of the extension will be provided to the member, unless there is agreement between the enrollee and Beacon to extend timeframes. Any appeal not properly acted on by Beacon within the established time limits shall be deemed resolved in favor of the member.

Chapter 7

# Billing Transactions

7.1. General Claim Policies

7.2. Claim Transaction Overview

## 7.1. General Claims Policies

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

### CLAIMS SUBMISSION

#### Our Policy

Most Beacon provider services agreements require claims to be submitted within 60 days of the provision of covered services. For Medi-Cal lines of business, please contact Provider Relations for information on the health plan-specific timely filing limit.

Beacon will deny claims not received within applicable state mandated or contractually required timely filing limits. A claim must contain no defect or impropriety, including a lack of any required substantiating documents, HIPAA compliant coding or other particular circumstance requiring special treatment that prevents timely payments from being made. If the claim does not contain all required information, it may be denied. If applicable state law defines “clean claim”, Beacon applies the state-mandated definition.

#### Claims Submission Guidelines

- Contact a Beacon Autism Services Care Coordinator prior to rendering care to receive authorization for the service.
- Collect applicable co-payments or co-insurance from member.
- Complete all required fields in Beacon’s eServices system.
- Submit claims either through paper submission using a CMS 1500 form, eServices, or through Electronic Data Interchange (EDI). Claims must be submitted within 60 days from the date of service. For Medi-Cal lines of business, please contact Provider Relations for information on the health plan-specific timely filing limit.
- Bill only for services rendered within the time span of authorization.
- Contact a Beacon Autism Services Care Coordinator for direction if authorized services need to be used after the authorization has expired.
- Contact a Beacon Autism Services Care Coordinator for direction if services that need to be used exceed the units of the authorization.
- Do not bill the member for any difference between your Beacon contracted rate and your standard rate. This practice is called “balance billing” and is not permitted by Beacon.

### DEFINITION OF “CLEAN CLAIM”

A clean claim – as discussed in this provider manual, he 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.

The Center for Medicare and Medicaid Services (CMS) developed claim forms that record the information needed to process and generate provider reimbursement. The CMS-1500 form or its successor is for use by outpatient providers such as physicians, radiologists and other non-institutional providers. The required elements of a clean claim must be complete, legible and accurate. The CMS 1500 or its successor claim form contains the following information including but not limited to: patient name, patient’s date of birth,

covered member's identification number, provider's name, address, tax identification number, NPI number, date(s), place of service, ICD10 code(s), CPT 4 or HCPCS code(s), revenue code(s), services and supplied provided, charges and such other information or attachments that may be agreed upon by the parties.

## 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 redistributed or dissemination of that information by a provider for any purpose other than the accurate accounting of behavioral health claims is considered an illegal use of confidential information.

## PROHIBITION OF BILLING MEMBERS

Providers are not permitted to bill health plan members under any circumstances for covered services rendered, excluding co-payments when appropriate.

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

## CLAIM TURNAROUND TIME

All clean claims will be adjudicated within 30 days from the date on which Beacon receives the claim.

## CODING

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

- Providers are required to submit HIPAA-compliant coding on all claims submissions, which 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 listing approved by CMS and HIPAA. In order to be considered payment by Beacon, all claims must have a Primary ICD-10 diagnosis. All diagnosis codes submitted on a claim form must be a complete diagnosis code with appropriate check digits.

## CLAIM DENIALS

Beacon will process claims promptly upon receipt and complete all transactions within regulatory and contractual standards. Beacon will inform the provider of any reasons for denials, providing appropriate notice regarding corrective action or information required. The Date of Denial is the date of the postmark or electronic mark accurately setting forth the date when the denial or notice was electronically available, transmitted or deposited in the U.S. Mail. Beacon will send the provider and/or make available online an explanation of payment (EOP) or other notification for each claim submitted.

Claims can be denied for the following reasons:

1. **Problem with Claim**
    a. Claims is missing required information
    b. Claim was not submitted on time
    c. Claim was a duplicate – date of service already paid for the same day
    d. Claims was for same day services
2. **Problem with Authorization**
    a. Provider was not authorized
    b. CPT/HCPCS code was not authorized
    c. Date of service not covered within the authorization dates
    d. Authorization exhausted
    e. Therapy was determined not medically necessary
3. **Problem with Eligibility/Benefits**
    a. Diagnosis not covered
    b. CPT/HCPCS code not covered
    c. Member ineligible
    d. Benefits exhausted

Whenever a provider receives a claim denial related to a claims error, the claim must be corrected and resubmitted within 30 days in order to receive reimbursement.

## MULTIPLE SERVICES ON THE SAME DAY

The standard rule is that only one service (CPT/HCPCS) code is paid per day. The following are exceptions to the rule:

1. Patient sees two different providers on the same day (example: BCBA and ABA Tutor)

2. Patient is seen for ABA therapy & BCBA supervision which occurs on the same day.

Whenever an exception applies, both CPT/HCPCS codes are paid on the same day.

## COORDINATION OF BENEFITS (COB)

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

- When it is determined that Beacon is the secondary payer, claims must be submitted with a copy of the primary insurance's explanation of benefits report and received by Beacon within 60 days of the date on the EOB.
- Beacon reserves the right of recovery for all claims in which a primary payment was made prior to receiving coordination of benefits (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.

## CO-PAYMENTS

In most benefit plans, members bear some of the cost of behavioral health services by paying a co-payment, coinsurance, and/or deductible. Deductible amounts and structure may vary from plan to plan. Some deductibles are combined with medical services or there may be separate individual or family deductible amounts.

### Our Policy

Members should be billed for deductibles after claims processing yields an Explanation of Benefits indicating member responsibility. For co-payments, we encourage you to require payment at the time of service to avoid uncollectible bad debts.

It is your sole responsibility to collect member payments due.

Members are never to be charged in advance of the delivery of services. Benefit plans often provide for annual co-payment or coinsurance maximums. If a member states that he or she has reached such a maximum, call Beacon to confirm the amount and status of the member's co-payment maximum.

### What Beacon Will Do

- Determine the member's co-pay or deductible
- Provide both the member and the provider with a form that requires a signature stating the member's co-pay or deductible, and that it is the responsibility of the provider to collect it

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.

## CLAIMS INQUIRIES AND RESOURCES

Additional information is available through the following resources:

### Email Contact

- **West Coast**

- provider.inquiry@beaconhealthoptions.com
- edi.operations@beaconhealthoptions.com

### Telephone

- **Claims Hotline**
  - West Coast (Hours of operation are 8:30 a.m. to 5 p.m., Monday through Friday) - 855.834.5654
- **Beacon Autism Services Care Coordinators**

| | |
|---|---|
| West Coast | 855.834.5654 |
| NY/MA | 855.856.0579 |
| Health First | 855.371.8096 |

### ELECTRONIC MEDIA OPTIONS

Providers are expected to complete claim transactions electronically through one of the following:

- **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 004.
- **eServices** enables providers to submit inpatient and outpatient claims without completing a CMS 1500 or UB04 claim form. Because so 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.

## 7.2. Claim Transaction Overview

### PAPER CLAIM TRANSACTIONS

Providers are encouraged to submit claims where electronic methods are available. 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 claim form. No other form is accepted.

### East Coast

Mail paper claims to:

- **West Coast:**

  Beacon
  Claims Department
  P.O. Box 1864
  Hicksville, NY 11801-1864

## Professional Services: Instructions for Completing the CMS 1500 Form

Table 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.

**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.

| 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 |
| 10a-c | Yes | Member's Condition Related to Employment |
| 11 | No | Member's Policy, Group or FICA Number (if applicable) |
| 11a | No | Member's Date of Birth (MM, DD, YY) and Sex (check box) |
| 11b | No | Employer's Name or School Name (if applicable) |
| 11c | No | Insurance Plan Name or Program Name (if applicable) |

| TABLE BLOCK # | REQUIRED? | DESCRIPTION |
|---|---|---|
| 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) |
| 17 B | 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 |
| 24e | Yes | Diagnosis Code – 1,2,3 or 4 |
| 24f | Yes | Charges |
| 24g | Yes | Days or Units |
| 24h | No | EPSDT |
| 24i | No | ID Qualifier |
| 24j | Yes | Rendering Provider Name and Rendering Provider NPI |

| TABLE BLOCK # | REQUIRED? | DESCRIPTION |
|---|---|---|
| 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 or Physician/Practitioner nx NPI |
| 32 | Yes | Name and address of facility where services were rendered (Site ID). If missing, a claim specialist will choose the site shown as 'primary' in Beacon's database. |
| 32a | No | NPI of Servicing Facility |
| 33 | Yes | Provider Name |
| 33a | Yes | Billing Provider NPI |
| 33b | No | Pay to Provider Beacon ID Number |

## PAPER RESUBMISSION

- If a 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 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 submitting 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 of the EOB. A claim package postmarked on the 120th 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

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

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

Submit completed *90-Day Waiver Forms* to the address below:

- **West Coast**

  Beacon
  Claims Department/90-Day Waivers
  P.O. Box 1864
  Hicksville, NY 11801-1864

## PAPER REQUEST FOR ADJUSTMENT OR VOID

- 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 claim as you would like your financial payment to be, with all required elements; place the REC.ID in box 19 of the CMS 1500 claim 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:

- **West Coast**

  Beacon
  Claims Department – Adjustment Requests
  P.O. Box 1864
  Hicksville, NY 11801-1864

### Completion of the *Adjustment/Void Request Form*

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

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

# Appendix A
# Frequently Asked Questions

# Frequently Asked Questions

| # | QUESTION | ANSWER |
|---|---|---|
| 1 | **Who is Beacon Autism Services?** | The Beacon Autism Services division of Beacon started as Autism Services Group (ASG) the first organized private sector human services entity focused exclusively on the quality management of autism insurance benefits. Specifically, ASG was acquired by Beacon Health Strategies in 2011 and continues to function as Beacon Autism Services. Beacon Autism Services is an administrative services organization working with health insurance plans, self-insured employers and others to administer Autism Spectrum Disorder (ASD) and other Developmental Disability (DD) services and benefits.<br>Beacon's Autism Services network is composed of Board Certified Behavior Analysts (BCBA), Board Certified Assistant Behavioral Analysts (BCaBA), ABA paraprofessionals and other clinicians. Their mission is to deliver comprehensive assessments and Applied Behavior Analysis (ABA) therapy that is consistent, effective, and evidence-based. The aim is to bridge the gap, as early and rapidly as possible, between the person's chronological age and their developmental age and enable mainstream adjustment to the extent achievable.<br>The company arranges access for members of contracted health plans to its network of BCBA, BCaBA and ABA paraprofessionals and then in turn, our Beacon Care Coordinators assure coordination of care with parents and all treating professionals. |
| 2 | **What if a practitioner employed or under contract leaves our facility network?** | Provider agencies/facilities must notify Beacon when each Practitioner joins or leaves their employ. Every new practitioner must be credentialed through Beacon before providing services. |
| 3 | **What number do I put on my W-9?** | Make sure you indicated the one Taxpayer Identification Number (TIN) with which you will bill on your W-9 Form. It will be either your Social Security Number (SSN) OR your Employer Identification Number (EIN) but NOT both numbers. |
| 4 | **What is an NPI number and how do I obtain one?** | NPI numbers are required for claim submission. NPI stands for "National Provider Identifier." This number is assigned by the National Plan and Provider Enumeration (NPPES). The purpose of assigning these numbers is to improve the efficiency and effectiveness of the electronic transmission of health information. |
| 5 | **How often must credentialing be renewed?** | Credentialing must be completed once every 36 months. You will receive written notice from Beacon prior to your credentialing anniversary date that your credentialing must be renewed. |
| 6 | **Who can I contact with specific questions or comments?** | **For California Business:**<br>Depending on the inquiry, you may call 855.834.5654 and follow the prompts. Below are specific departments that may assist you: |

| # | QUESTION | ANSWER |
|---|---|---|
| | | ▪ **Provider Relations**<br>As your liaison to Beacon they provide provider education, trainings, eServices, etc.<br>***Fax Number:*** 877.321.1779<br>***Email:*** Providerinquiry@beaconhealthoptions.com<br>▪ In charge of credentialing and provider data maintenance<br>**Email:** Providerinquiry@beaconhealthoptions.com<br>▪ **Network Development**<br>Questions about rates or contracting<br>**General Network Development Email**:<br>Provider.Inquiry@beaconhealthoptions.com<br>▪ **Claims Department**<br>Verify claims status or any claims inquiry<br>***Phone Number:*** 855.834.5654 Option 2, then 2<br>***Email:*** Claims@chipa.com |
| **7** | **Do I have to notify anyone if I change my name, address, telephone number, or Tax Identification Number?** | Yes. You are required to notify Beacon within 10 calendar days, in writing, of any changes to your practice information. This is especially important for accurate claims processing. Provider shall provide such notice to IPA and payor as applicable in writing, 90 days prior to a planned change or as soon as provider becomes aware of an unplanned change. |
| **8** | **Since our practice group has a contract with Beacon, does that mean all of our affiliated clinicians are considered part of the Beacon network?** | No. Only clinicians credentialed through Beacon are considered network clinicians. The certification of a group does not guarantee that all clinicians at that agency are part of the Beacon network. |
| **9** | **As a contracted group, are we required to notify Beacon, if we discontinue or change a program or service?** | Yes. Contracted groups are required to provide Beacon with written notification of changes in the services they offer. Provider shall provide such notice to IPA and payor as applicable in writing, 90 days prior to a planned change or as soon as provider becomes aware of an unplanned change. |
| **10** | **If my practice is filling up or if I am going to take a leave of absence from my practice, may I choose to be unavailable for new Beacon referrals?** | Yes. You may request to be listed in our database as unavailable at one or more of your practice locations for up to six months. Provider shall provide such notice to IPA and payor as applicable in writing, 90 days prior to a planned change or as soon as provider becomes aware of an unplanned change. |
| **11** | **Should I routinely contact Beacon** | Yes. Services and/or conditions not covered under the members' specific benefit plan are not eligible for payment. Each health plan complies with |

| # | QUESTION | ANSWER |
|---|---|---|
| | **regarding eligibility and benefits?** | regulatory requirements related to coverage election periods and payment grace periods. These requirements can lead to delays in Beacon's knowledge of a members' eligibility status. As a result, the member is usually the best source for timely information about eligibility; coverage changes and services utilized to-date. |
| 12 | **Can I inquire about a member's current eligibility, and benefits?** | **For CA Business:**<br>Contact our CA call center at 855.834.5654 Option 2, then 4<br><br>**For MA, NJ, and NY Business:**<br>Contact our MA call center at 855.856.0579. |
| 13 | **If a member discontinues treatment but returns several months later, is another in-take required at that time?** | Yes. You should consider this a new episode of care, requiring the completion. Keep in mind that if the member returns to treatment within six months of his or her last certification, that certification is still valid up to the benefit limit as long as the member's eligibility remains active. Renewal of certification will be required at the end of that one-year period. |
| 14 | **Will I be notified when a registration expires?** | No. Please refer to the effective date on the most recent registration letter. The registration is typically valid for 12 months from the date of issue (up to the benefit limit as long as the member's eligibility remains active). |
| 15 | **Am I expected to coordinate care with a member's primary care physician or other health care professionals?** | Yes. Beacon requires network clinicians to pursue coordination of care with the member's primary physician as well as other treating medical or behavioral health clinicians. A signed release of information should be maintained in the clinical record. In the event that a member declines consent to the release of information, his or her refusal should be documented along with the reason for the refusal. In either case, the education you provide regarding risks and benefits of coordinated care should be noted. |
| 16 | **For the Behavior Identification Assessment (0359T), it says one unit is two hours. Are we going to able to bill for more than one unit for the assessment?** | Beacon typically authorizes eight hours for the completion of an Initial Assessment. Providers will only be able to bill 0359T once which will account for two of the eight hours for an assessment. The remaining hours will be authorized and billable under the codes 0360T/+0361T (a total of 12 units = 6 hours) |
| 17 | **As per the new codes, which would we be utilizing for Direct Supervision?** | Under the new ABA CPT codes Supervision by a BCBA would be covered under the codes 0368T/+0369T. |

# Appendix B
# Glossary of Terms

# Glossary of Terms

## ABA THERAPIST/TUTOR/PARAPROFESSIONAL

An individual who works with a member to implement an ABA treatment plan under the supervision of a certified BCBA and meets minimum requirements as defined by the following:

1. A high school diploma or the equivalent with 500 hours of employment providing paraprofessional services incorporating 30 hours of competency-based training designed by a certified behavioral analyst and six months experience working with persons with developmental disabilities
2. An associate's degree in either human, social or educational discipline or certification related to behavior management from an accredited community college or educational institution. Minimum must include 12 semester hours in psychology, education, social work, behavior science, human development, or related field with six months experience working with persons with developmental disabilities.

## ABA THERAPY

Applied behavior analysis (ABA) is the science that involves using modern behavioral learning theory to modify behaviors. The use of these techniques and principles are implemented to bring about meaningful and positive change in behavior.

## ABUSE

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to government-sponsored programs, and other health care programs/plans, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to federally and/or state-funded health care programs, and other payers.

## APPEAL

A specific request to reverse an adverse determination or potential restriction of benefit reimbursement.

## AUTISM (ASD)

A developmental disorder characterized by impaired social interaction and communication, and by restricted and repetitive behavior. The acronym ASD refers to 'Autism Spectrum Disorder'.

## BCaBA (BOARD CERTIFIED ASSISTANT BEHAVIOR ANALYST)

The BCaBA conducts descriptive behavioral assessments and is able to design ethical and effective behavior analytic interventions for clients and interpret the results. The BCaBA designs and oversees interventions in familiar cases (e.g., similar to those encountered during their training) that are consistent with the dimensions of applied behavior analysis. The BCaBA obtains technical direction from a BCBA for unfamiliar situations. The BCaBA is able to teach others to carry out interventions once the BCaBA has demonstrated competency with the procedures involved under the direct supervision of a BCBA. The BCaBA may assist a BCBA with the design and delivery of introductory level instruction in behavior analysis. It is mandatory that each BCaBA practice under the supervision of a BCBA. Governmental entities, third-party insurance plans and others utilizing BCaBAs must require this supervision.

## BCBA (BOARD CERTIFIED BEHAVIOR ANALYST)

An individual that conducts descriptive and systematic behavioral assessments, including functional analyses, and provides behavior analytic interpretations of the results. The BCBA designs and supervises behavior analytic interventions. The BCBA is able to effectively develop and implement appropriate assessment and intervention methods for use in unfamiliar situations and for a range of cases. The BCBA teaches others to carry out ethical and effective behavior analytic interventions based on published research and designs and delivers instruction in behavior analysis.

## CARE COORDINATOR

A Beacon employee who acts as a liaison with parents and the health community to ensure continuum of care and support for members. Care Coordinators telephonically screen referrals and assigns appropriate level of care to provide services to members while also gathering the required clinical and financial information telephonically to ensure appropriate level of care for its members.

## CLEAN CLAIM

A claim that meets the following conditions:

- Is sent on a CMS 1500 claim form, or an accepted electronic equivalent (National Standard Format Version 2.0)
- The information requested by Beacon (i.e., authorized CPT/ HCPCS code, ICD-10 code, rendering provider's tax ID number is present and legible on the CMS 1500 or an accepted electronic equivalent) and the form is 100% complete with no missing or illegible information
- The claim is sent by a Beacon and appropriate Payer contracted provider or provider group. The provider must be in "good" and "active" status in both panels or have signed a single case agreement (SCA) with Beacon for autism services.

## CLINICIAN

A licensed or certified professional that has contracted to deliver behavioral health care services to members.

## CMS 1500

The Form CMS 1500 (Health Insurance Claim Form) is the standard claim form used by a non-institutional provider or supplier to bill Medicare contractors and durable medical equipment contractors when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims.

## CO-PAYMENT

A cost-sharing arrangement in which a member pays a specified charge for a specified service, such as $20 for an office visit, for example. The member usually is responsible for payment at the time the health care is rendered. Typical co-payments are fixed or variable flat amounts for clinician office visits, prescriptions or hospital services. Sometimes the term "co-payment" generically refers to both a flat dollar co-payment.

## CREDENTIALING

The process by which a Clinician or Agency is accepted into the applicable Health plan network and by which that association is maintained on a regular basis.

## DEDUCTIBLE

The annual amount of charges for behavioral health care services as provided in the member's benefit plan, which the member is required to pay prior to receiving any benefit payment under the member's plan.

## EMERGENCY

A serious situation that arises suddenly and requires immediate care and treatment to avoid jeopardy to life or health. See below for appointment access standards.

## EMERGENCY- LIFE THREATENING

A situation requiring immediate appointment availability in which there is imminent risk of harm or death to self or others due to a medical or psychiatric condition.

## EMERGENCY- NON-LIFE THREATENING

A situation requiring appointment availability within six hours in which immediate assessment or care is needed to stabilize a condition or situation, but there is no imminent risk of harm or death to self or others.

## FRAUD

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

## HIPAA

The Health Insurance Portability and Accountability Act, by which a set of national standards are set for, the protection of certain health care information. The standards address the use and disclosure of an individual's "Protected Health Information" (PHI) by organizations subject to the Privacy Rule ("covered entities").

## MEDICAL NECESSITY

Generally, the evaluation of health care services to determine if they meet plan criteria for coverage as medically appropriate and necessary to meet basic health needs; are consistent with the diagnosis or condition; are rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment. This definition may vary according to member benefit plans or state laws (also referred to as clinical necessity).

## MEMBER

An individual who meets eligibility requirements and for whom premium payments for specified benefits of the contractual agreement are paid. Also may be referred to as a plan participant or enrollee.

## NATIONAL PROVIDER IDENTIFIER (NPI)

The National Provider Identifier (NPI) is a unique, government-issued, standard identification number for individual health care providers and provider organizations like clinics, hospitals, schools and group practices.

## PAYOR

An organization that provides health care expense coverage.

## PHI

Protected Health Information

## TAX IDENTIFICATION NUMBER (TIN)

A Taxpayer Identification Number (TIN) is an identification number used by the Internal Revenue Service (IRS) in the administration of tax laws.

## QUALITY ASSURANCE

A formal set of activities to review and affect the quality of services provided. Quality assurance includes assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient services. Federal and state regulations typically require health plans to have quality assurance programs.

## QUALITY IMPROVEMENT

A continuous process that identifies opportunities for improvement in health care delivery, tests solutions, and routinely monitors solutions for effectiveness.

## REJECTED CLAIM

A claim that does not meet one of the above conditions of a “clean claim”.

## ROI

Release of Information

## W-9 FORM

A document that is issued by the United States Department of the Treasury's IRS and is used when a person or company needs to request a TIN, claims for exemption and specific certifications from a person, company, trust or estate in the U.S. The form must be completed and returned to the requesting person or company, which used the information for tax filing purposes.

## WASTE

An over-utilization of services or other practices that result in unnecessary costs.

# Appendix C
# Recommended BCBA Assessment and Re-Assessment Format

# Recommended BCBA Assessment & Re-assessment Format

Child's Name: Member Name(s):

Child's Age: Member ID:

Child's DOB:

Date of report:

Evaluator's Name:

Type of Assessment:

_____Initial Assessment _____Reassessment _____Assessment for Early Intervention
*(Applicable to MA plans only)*

**Reassessment *(if applicable)*:**

Treatment Plan updates should be submitted at a frequency as required by state-specific or account-specific requirements.

The Treatment Plan update should reflect any relevant life changes (family, school, services, health, and/or medications) and the member's progress in the objectives, and target behaviors identified on the Initial Treatment Plan. Objectives should be listed in the same order as listed on the original report and include graphical progress as clinically appropriate.

In addition, new objectives, target behaviors and/or behavior plans should be added as appropriate and indicated as such.

**Documents Reviewed:**

Documents reviewed should include the following:

- Diagnostic report
- IEP or IFSP (as applicable)
- Reports of other services provided (OT, PT, SLP, Social Skills Training, etc.)
- Psychiatric assessment (if applicable)

Please note any additional documents that are reviewed as part of the assessment.

**Background Information:**

Description of background information should include a brief summary of:

- Previous treatments and results
- Current treatments and progress (please include supplements and any dietary modifications if applicable)
- Current living situation
- Relevant family history

- Medical history – particularly seizure disorder or major psychiatric disorder
    - Include current medications
        - Are psychotropic medications being prescribed?
            - Name of medication
            - Prescribing Doctor
- Education status
    - Where does the child attend school?
    - Specialized classroom?
    - Require an aide?
    - Treatments received within school?

**Observations:**

Include dates of observations and description. Assessment must include at least two direct observations of the client.

**Strengths and Weaknesses:**

Include a description of the child's strengths and weaknesses. Strengths and weaknesses may be determined through assessments such as the CARS, Vineland or VB-MAPP.

**Maladaptive Behaviors:**

Identify target maladaptive behaviors. These are behaviors that are targeted for reduction. When stating behavior objectives include current topography, intensity, and frequency. Note progress made on behavior objectives from last progress report. If an Initial Assessment please include baseline levels for all maladaptive behaviors.

**Assessments Conducted:**

Identify any assessments conducted and a summary of the results.

Possible assessments include; FAST, MAS, QABF, A-DOS, ABLLS, VB-MAPP, Functional Assessment Interview, Functional Analysis, etc.

*Clinician is free to determine the most appropriate assessment to evaluate the child. However, if a target behavior has been identified an assessment should be conducted to determine the function of the behavior.*

**Behavior Plan *(if applicable)*:**

Target behaviors must be identified.

Behavior Plan should include both preventative and reactive strategies. Note any functional replacement skills identified.

**Data Collected:**

In the case of a reassessment present summary of data collected for each objective and maladaptive behavior. Please be sure to note treatment objectives that have been achieved or show significant improvement. Also note objectives that show a lack of progress and related treatment revisions.

**Family Involvement:**

Include a description of family involvement and family members targeted for training.

List specific objectives identified for parent/family training note progress from last reporting period. *If an Initial Assessment please include baseline levels for all parent training objectives.*

Document any assistance provided to caregivers or others to carry out the approved behavior support/maintenance plans.

Provider observation of the caregivers or other plan implementers and the member's behaviors to assess proper implementation of the behavior support/maintenance plan and interventions made based on those observations.

State approach to continuous monitoring of client's progress and related modifications of the treatment plan as the parents/guardians management skills improve, and the client's deficits are modified.

**Generalization Training:**

Include description of training plan for generalizing skills into all areas of child's environment.

**Skills To Be Taught (Goals):**

Identify skills to be taught.

Objectives should relate to the core deficits of Autism Spectrum Disorders and should be derived from the functional assessment and/or skills-based assessments that occur prior to initiating treatment.

Objectives should be measurable, observable, age appropriate and achievable. The statement of the objectives should include the baseline measurement, current level of performance, and the anticipated level of achievement of the member at the end of the authorization period.

Objectives should neither be educational in nature nor overlap IEP objectives. Please provide justification if objectives are included in the plan which would fit into the above mentioned categories.

**Social Skills Goals (if applicable):**

Identify skills to be taught in a Social Skills Group setting.

Each skill identified should include a baseline measure of current functioning and target dates for mastery of objective. Skill should be defined in terms of measurable objectives and criteria for mastery. Benchmarks should be in 6 month increments.

**Preference Assessment:**

A preference assessment should be conducted in order to determine appropriate reinforcers to be incorporated into client's treatment.

Specify reinforcers and potential reinforcers identified for use.

For a reassessment note any changes to previously identified reinforcers, i.e. fading from food rewards to tokens system.

**Risk Assessment (if applicable):**

The risk assessment should include a description of the risks associated with engaging in treatment as well as refusing treatment plan.

**Transition Plan (if applicable):**

Transition plans may include several components depending on the client's situation. A transition plan

should be created when:

a. The client is preparing to transition from a client-based intensive ABA program to a less intensive level of care.

b. The client is preparing to transition to a less restrictive environment placement.

c. The client is preparing to transition from a home-based ABA intervention program to a school-based program.

d. A transition plan should also address how the client will transition into adulthood. For example, will the focus be on academic skills or life skills.

**Discharge Criteria:**

Discharge Criteria must include requirements for discharge, discharge date, next level of care, and linkages with other services.

**Crisis Plan:**

*If child does not display maladaptive behaviors that are a risk for harm to self or others this should be noted and the section labeled N/A.*

Please check risk factors as applicable.

- ☐ Assaultive behavior
- ☐ Elopement
- ☐ Self-Injurious Behavior (SIB)
- ☐ Sexually offending behavior
- ☐ Fire setting
- ☐ Current substance abuse
- ☐ Impulsive Behavior
- ☐ Psychotic symptoms
- ☐ Self-mutilation/cutting
- ☐ Caring for ill family member
- ☐ Current family violence (abuse, violence)
- ☐ Coping with significant loss (job, relationship, financial)
- ☐ Prior psychiatric inpatient admission
- ☐ Other _____

Suicidality?:
☐ Not Present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt (last 12 months)

Homicidality?:
☐ Not Present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt (last 12 months)

A crisis plan includes active steps or self-help methods to encourage de-escalate or defuse crisis situations, names and phone numbers of contacts that can assist in the prevention or de-escalation of behaviors. Please note specific instructions on what parents/guardians should do after hours. (IE: Call 9-1-1 in case of an emergency situation.)

**Communication with Other Providers:**

Please check boxes as applicable.

| | |
|---|---|
| Have you communicated with the member's prescriber of psychotropic drugs? | ☐ Yes ☐ No ☐ Member Declined<br>☐ N/A, Provider is the Prescriber<br>☐ N/A, Member not on medication |
| Have you communicated with the member's PCP? | ☐ Yes ☐ No ☐ Member Declined |
| Have you documented the communication or member declination? | ☐ Yes ☐ No ☐ N/A; I did not contact PCP |
| Have you been in communication with other Behavioral Health (BH) providers for this member? | ☐ Yes ☐ No ☐ Member Declined<br>☐ N/A; I did not contact PCP |
| If yes, please indicate the type of BH provider. | |

**Summary and Recommendations:**

A summary of the assessment should be included with justification for treatment recommendations.

Include breakdown of number of hours requested for services by CPT code.

| CPT CODE | DESCRIPTION OF SERVICE | # OF HOURS REQUESTED | BREAKDOWN PER WEEK | LOCATION (WHERE SERVICES ARE TO BE DELIVERED) |
|---|---|---|---|---|
| *EX: 0364T/+0365T* | *ABA Therapy by Para* | *260* | *10 hours per week* | *In home* |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |

**BCBA Signature:**

_____ _____

Signature Date

**Parent Signature:**

_____ _____

Signature Date

# Appendix D
# Credentialing Checklists

# Credentialing Checklists

**CHECKLIST A**

| CRITERIA SOURCE | MD/DO | PhD | RN | MA | ADDICTION | ABA |
|---|---|---|---|---|---|---|
| License/Certification State Board of Registration (ABA verified at the National level www.bacb.com/index.php?page=00155) | X | X | X | X | X | X (if applicable) |
| Board Certification –If a provider self identifies board certification; verification is required. (Must be verified within 180 day prior to credentialing determination) ABMS AOA(DOs) AANP/ANCC (NPICNS) | X | | X | | | X |
| Education/Training (Initial credentialing only; no time limits) institution(s) cited on the application State Board of Registrations ABMS AMA | X | X | X | X | X | X |
| DEA or CDS Certificates* (Must be active at time of credentialing determination) *DEA certification through deanumber.com required for CA providers/prescribers; Copy of the DEA or CDS certificate | X | | X | | | |
| Work History (5 years with no unexplained gaps; must be "verified" within 365 days of credentialing determination) Application or CV (Note: For 6-12 month gaps in work history telephone clarification is obtained; for gaps greater than 12-months a written explanation is required from the practitioner) | X | X | X | X | X | X |
| Malpractice insurance** (Must be current at the time of the credentialing determination) Copy of malpractice policy | $1M/$3M | | | | | |
| Malpractice History NPDB | X | X | X | X | X | X |

** The appropriate State Board of Registration verifies that it performs primary source verification of education and training for independent practitioners prior to licensing. Written confirmation is obtained from the specialty board annually. If the licensing board does not provide written attestation regarding its primary source verification, education and training is verified through written or oral confirmation from the university, college, or training program that is indicated on the practitioner's application. If the practitioner indicates he/she is board certified, verification of board certification with ABMS is considered to meet the education/training verification requirement*

*** Certain Plans require minimums at $1,300,000/$3,900,000*

**CHECKLIST B**

| CRITERIA SOURCE | MD/DO | PhD | RN | MA | ADDICTION | ABA |
|---|---|---|---|---|---|---|
| **Medicare & Medicaid Sanctions** | | | | | | |
| NDPB | X | | X | X | X | X |
| OMIG (State-specific) | X | | X | X | X | X |
| HIPDB SAM Medi-Cal-CA providers only www.medi-cal.ca.gov | X | X | X | X | X | X |
| **State Sanctions, Restrictions on Licensure, and Limitations on Scope of Practice** | | | | | | |
| NPDB, HIPDB, State Licensing Boards | X | X | X | X | X | X |
| Medicare Opt-out Status CMS website: www.ngsmedicare.com<br>Palmetto GBA Opt Out Listing (CA - Northern & Southern Listing) | X | X | | X | X | X |
| **Federal Program Exclusion** | | | | | | |
| NPDB | X | X | X | X | X | X |
| HIPDB | X | X | X | X | X | X |
| SAM Medi-Cal-CA providers only www.medi-cal.ca.gov | X | X | X | X | X | X |

# Appendix E
# Provider Performance Management Audit Guidelines

# Provider Performance Management Audit Guidelines

| AUDIT ELEMENTS | CRITERIA | EVIDENCE |
|---|---|---|
| **Operational/General Organization** | | |
| This is a review of the Provider Agency's:<br>☐ Organizational Structure<br>☐ Policies, practices, and procedures<br>☐ Training Records | ☐ Description of Organization<br>☐ Reporting relationships and functions<br>☐ Core business processes<br>☐ Training and education programs | ☐ Org chart<br>☐ Policies addressing member and Beacon complaints<br>☐ Policies addressing security and confidentiality breaches<br>☐ Training completion certificates or training attendance log |
| **Credentialing** | | |
| This is a review of the Provider Agency's:<br>☐ Provider Roster<br>☐ Individual employee (provider) files | ☐ Contracted providers available for credentialing<br>☐ Contracted Para's meet all education and experience requirements<br>☐ Contracted providers approved by Beacon prior to 1st date of service | ☐ Verification of paraprofessionals education and work experience applicable to ABA<br>☐ Verification of provider, professional and paraprofessionals continuing education and training applicable to ABA<br>☐ Beacon approval letter<br>☐ Employees (Providers) acknowledgment on HIPAA, Security and Confidentiality Training |
| **Clinical Management** | | |
| This is a review of the Provider Agency's:<br>☐ Individual Providers' Case Files<br>☐ Financial/Billing Records | ☐ Delivered services were authorized<br>☐ Appointment scheduled within 10 business days of request for services<br>☐ Data Entry/Encounter data submitted within 90 of Date of Service | ☐ Clinical records, schedules and other documents that services billed were provided to members |

| AUDIT ELEMENTS | CRITERIA | EVIDENCE |
|---|---|---|
| **Site Visit** | | |
| This is a review of the Provider Agency's:<br>□ Physical Accessibility<br>□ Physical Appearance & Condition<br>□ Record Keeping | □ Agency location is clean and well maintained, with no obvious structural defects and is handicap accessible<br>□ Records are in a designated secure location and are in a logical/alphabetical order | □ Clinical records and clinical documentation on available for review<br>□ Access to clinical records and documentation are secured<br>□ Access to employee (provider) files are secured<br>□ Workspace for Audit team with access to outlets, fax/scanner/printer is available |