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 Health Strategies Provider Manual

Updated June 2021

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The following information is available via the health plan-specific Contact Information sheet available on Beacon's web site at www.beaconhealthoptions.com

- Health plan EDI code
- Beacon hours of operation
- Beacon TTY number
- Interactive Voice Recognition (IVR)
- Beacon's Member Services phone number
- Beacon Claims Department address and phone number
- Beacon Clinical Appeals Coordinator phone number
- Plan/state required filing notice filing limit
- Beacon Provider Relations phone
- Time limits for filing outpatient claims
- Time limits for filing inpatient claims
- State Medicaid office address and phone
- State Fair Hearing office address and phone
    - Number of days for fair hearing decisions
- State Independent Review Organization address and phone

Chapter 1

Introduction

1.1. Introduction to Beacon Health Strategies LLC

1.2. About this Provider Manual

1.3. Quality Improvement Efforts on Integrated Care

1.4. Behavioral Health Services

1.1. Introduction

INTRODUCTION TO BEACON HEALTH STRATEGIES LLC

Beacon Health Strategies LLC (Beacon) is a managed behavioral health care company. Established in 1996, Beacon's mission is to partner with health plans and contracted providers to improve the delivery of behavioral healthcare for the members we serve.

Through these partnerships, Beacon provides care management services to members served by its health plan clients. Working closely with our plan partners, 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 through improved integration of behavioral health with medical care.

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.

This Manual serves as an administrative guide outlining Beacon's policies and procedures governing network participation, service provision, claims submission, quality management and improvement requirements. Detailed information regarding clinical processes, including authorizations, utilization review, Case Management, reconsiderations and appeals are found in this Manual. It also covers billing transactions and Beacon's level-of-care (LOC) criteria, which are accessible only through **eServices** or by calling Beacon.

The Manual is posted on Beacon's website, www.beaconhealthoptions.com, and on Beacon's **eServices** provider portal; only the version on **eServices** includes Beacon's LOC criteria. Providers may request a printed copy of the Manual by calling their Beacon contract manager.

Updates to the Manual as permitted by the PSA are posted on Beacon's website, and notification may also be sent by postal mail and/or electronic mail. Beacon provides notification to network providers at least 30 days prior to the effective date of any material, policy or procedural change that affects providers, such as modification in payment or covered services, unless the change is mandated sooner by state or federal requirements.

1.3. Quality Improvement Efforts on Integrated Care

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.

QMP 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 QMP to continually assess quality of care, access to care, and compliance with medical necessity criteria.

1.4. Behavioral Health Services

DEFINITION OF BEHAVIORAL HEALTH

Beacon defines "behavioral health" as both acute and chronic psychiatric and substance use disorders as referenced in the most recent Diagnostic and Statistical Manual of Mental Disorders DSM and/or ICD of the American Psychiatric Association.

ACCESSIBLE INTERVENTION AND TREATMENT

Beacon promotes using health screenings for identification of behavioral health problems and patient education. Providers are expected to:

- inform members where to obtain behavioral health services
- understand that members may self-refer to any behavioral health care provider without a referral from the member's primary care provider

Providers who need to refer members for further behavioral health care should contact Beacon. Beacon continuously evaluates providers who offer services to monitor on-going behavioral health conditions, such as regular lab or ancillary medical tests and procedures.

OUTPATIENT BENEFITS

Outpatient behavioral health treatment is an essential component of a comprehensive healthcare delivery system. Plan members may access outpatient mental health and substance use services by self-referring to a network provider, by calling Beacon for a referral to a Beacon provider, or by referral through acute or emergency room encounters.

INPATIENT BENEFITS

Beacon is responsible for authorizing inpatient mental health and substance use services, as applicable.

FLORIDA MEDICAID: PROGRAM OVERVIEW

The State of Florida has offered Medicaid services since 1970. Medicaid is funded by both the state and federal government to provide health care coverage for eligible children, seniors, disabled adults, parents of children and pregnant women. The annual budget for the program is more than $25 billion, and makes up the largest part of the total Florida budget.

FLORIDA MEDICAID: STATEWIDE MEDICAID MANAGED CARE (SMMC)

The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, Florida Statutes) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as Statewide Medicaid Managed

Care (SMMC) and includes two programs: Managed Medical Assistance (MMA) and Long-term Care (LTC). More than 3.2 million Floridians are enrolled in Florida's SMMC program.

The overall objective is for Medicaid enrollees to receive all medically necessary services in a timely manner and in the most appropriate setting, thereby achieving the best possible quality outcomes while containing costs.

Chapter 2

Network Operations

2.1. Network Operations

2.2. Contracting and Maintaining Network Participation

2.3. Credentialing and Recredentialing

2.1. Network Operations

Beacon's Network Department is responsible for procurement and administrative management of Beacon's behavioral health provider network. For credentialing inquiries or Provider Relations questions, please email Miami_Partners@beaconhealthoptions.com or contact the National Provider Line at (800) 397-1630 (8 a.m.-8 p.m. ET) .

Providers may submit a request to join the Beacon network via the Beacon Health Options on-line portal at: https://www.beaconhealthoptions.com/providers/how-to-become-a-provider/.

2.2. Contracting and Maintaining Network Participation

CONTRACT PROCESS

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

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

MEDICARE NUMBER

Providers are required to obtain a Medicare number in order to provide covered services for Medicare. Please reference CMS and Medicare Provider Enrollment for additional information. All Provider information on file with CMS will be used for authorization of covered services and claims payment.

MEDICAID NUMBER

Providers are required to obtain a Medicaid number in order to provide covered services for a Medicaid or Florida Healthy Kids Member. This Medicaid number can be obtained through the State Medicaid office. All Provider information on file with Florida's Agency for Healthcare Administration (AHCA) will be used for authorization of covered services and claims payment.

PROVIDER TRAININGS

Trainings are provided, upon request, to all Providers and their staff regarding the requirements of their contract, Beacon shall also conduct ongoing trainings, as deemed necessary to ensure compliance with program standards.

PROVIDER REQUEST TO TERMINATE

Providers requesting to terminate from the network must adhere to the termination provisions set forth in their Agreement with Beacon. This notice can be emailed, mailed or faxed to the Provider Relations Department. The notification will be acknowledged by Beacon in writing and the Provider will be advised on procedures for transitioning members if indicated.

Beacon will work closely with the terminating Provider to address the member's needs and to ensure continuity of care. A provider who terminates his/her contract with Beacon must notify all Beacon members who are currently in care at the time and who have been in care with that Provider during the previous six (6) months. Treatment with these members must be completed or transferred to another Beacon provider within the continuity of care period.

BEACON'S RIGHT TO TERMINATE

Beacon has the right to terminate a provider's contract by giving written notice to the provider upon the occurrence of any of the following events:

- Provider's breach of any term or obligations of the contract;
- Provider's failure or inability to meet and maintain full credentialing status with Beacon;
- Provider's submission of false or misleading billing information;
- Restriction, qualification, suspension or revocation of provider's license or certification
- Restriction, qualification, suspension or revocation of provider's membership on the active medical staff of a hospital;
- Provider's exclusion from participation in the Medicare or Medicaid program;
- Provider's loss or reduction of liability insurance required under the contract with Beacon;
- Provider's insolvency, bankruptcy, or provider's assignment for the benefit of creditors;
- Provider's conviction, guilty plea, or plea of nolo contendere to any felony or crime involving moral turpitude;
- Any occurrence of serious misconduct which brings Beacon to the reasonable interpretation that a provider may be delivering clinically-inappropriate care;
- Provider's ability to provide services has become impaired;
- Provider's non-compliance with Beacon's processes, or
- Termination of Beacon's obligation to provide for or to arrange mental health and/or substance use disorder services for members.

STATUS CHANGE OR DEMOGRAPHIC CHANGE NOTIFICATIONS

It is the Provider's responsibility to notify Beacon, no later than ten (10) days of the occurrence, of any of the following issues:

- Licensing board actions
- Malpractice claims or arbitration
- Medicaid/Medicare sanctions
- Change in DEA registration status
- Hospital staff privilege changes
- Issues reported to NPDB
- Cancellation or material modification of professional liability insurance
- Complaints from members managed by Beacon
- Inability to meet accessibility standards
- NPI modifications
- Demographic modifications, including change of NPI or Tax Identification Number

2.3. Credentialing and Recredentialing

Beacon's credentialing processes for new *providers* seeking to contract with Beacon and recredentialing processes for *participating providers* currently contracted with Beacon are designed to comply with national

accreditation standards to which Beacon is or may be subject, as well as applicable state and/or federal laws, rules, and regulations. Credentialing and recredentialing is required for all *providers* and *participating providers*, respectively, including without limitation individual practitioners and organizations (clinics, facilities, or programs). All *provider/participating provider* office or facility locations where services are rendered and that share the same federal tax identification number that are identified in credentialing/ recredentialing applications will be considered for participation status under that application.

Providers and *participating providers* are credentialed and recredentialed, respectively, for participation status for designated services and/or level(s) of services. Should *participating providers* have other or additional services or levels of services available, additional credentialing and/or recredentialing may be necessary prior to designation as a '*participating provider*' for such additional services and/or levels of services. Services and/or levels of services for which a *participating provider* is not credentialed for are subject to all applicable out-of-network *authorization*, *certification*, and any benefit or coverage limitations under the *member's* benefit plan.

As provided for in Beacon's *policies and procedures*, decisions to approve or decline initial credentialing applications, to approve recredentialing applications, and/or to submit a given credentialing or recredentialing application for further review are made by the Beacon Health Options *National Credentialing Committee (NCC)*, or where applicable by a local Beacon established credentialing committee.

Participating providers have the right to:

- Request review of information submitted in support of credentialing or recredentialing applications
- Correct erroneous information collected during the credentialing or recredentialing processes
- Request information about the status of credentialing or recredentialing applications

All requests to review information must be submitted in writing. Verbal requests for the status of a credentialing or recredentialing application can be made by calling the Beacon National Provider Services Line at 800-397-1630, Mon. through Fri., 8 a.m. to 8 p.m. ET. Regardless of the above, Beacon will not release information obtained through the primary source verification process where prohibited by applicable state and/or federal laws, rules, and/or regulations.

Credentialing

Initial credentialing processes begin with submission of completed and signed applications, along with all required supporting documentation using one of the following methods:

- After completing the online universal credentialing process offered by the Council for Affordable Quality Healthcare (*CAQH*), give Beacon access to your credentialing information and ensure a current attestation. Call the *CAQH* Help Desk at 888-599-1771 for answers to your questions related to the *CAQH* application or website.
- Complete a Beacon paper or online application by calling the Beacon National Provider Services Line at 800-397-1630.

This includes without limitation attestation as to:

- Any limits on the *provider's* ability to perform essential functions of their position or operational status
- With respect to individual practitioner *providers*, the absence of any current illegal substance or drug use

- Any loss of required state licensure and/or certification
- Absence of felony convictions
- With respect to individual practitioner *providers*, any loss or limitation of privileges or disciplinary action
- The correctness and completeness of the application

Failure of a *provider* to submit a complete and signed credentialing application, and all required supporting documentation timely and as provided for in the credentialing application and/or requests from Beacon, may result in rejection of request for participation status with Beacon.

Recredentialing

Recredentialing for *participating providers* is required every three years, or such shorter period of time where required by a specific state law or regulation. The process for recredentialing begins approximately three months prior to the end of the initial credentialing cycle or the preceding recredentialing cycle, as applicable, and can be accomplished using one of the following methods:

- After completing the online universal credentialing process offered by the *Council for Affordable Quality Healthcare* (*CAQH*), give Beacon access to your credentialing information and ensure a current attestation. Call the *CAQH* Help Desk at 888-599-1771 for answers to your questions related to the *CAQH* application or website.
- We will mail a recredentialing application via USPS to the *participating provider* or notify the *participating provider* via email, voicemail, or fax that their online recredentialing application is available via *ProviderConnect*.

Required documentation includes without limitation attestation as to

- Any limits on the *participating provider's* ability to perform essential functions of their position or operational status
- With respect to individual practitioner *participating providers*, the absence of any current illegal substance or drug use
- The correctness and completeness of the application (including without limitation identification of any changes in or updates to information submitted during initial credentialing)

Failure of a *participating provider* to submit a complete and signed recredentialing application, including all required supporting documentation timely and as provided for in the recredentialing application and/or requests from Beacon, may result in termination of participation status with Beacon and such *providers* may be required to go through the initial credentialing process.

Standards

Standards applicable to *providers* in the initial credentialing process and to *participating providers* in the recredentialing process include, but are not limited to the following:

- Current, unencumbered (not subject to probation, suspension, supervision and/or other monitoring requirements), and valid license to practice as an independent provider at the highest level certified or approved by the state or states in which services are performed for the *provider*/*participating provider's* specialty (individual practitioners)

- Current, unencumbered (not subject to probation, suspension, supervision and/or other monitoring requirements), and valid license to practice and/or operate independently at the highest level certified or approved by the state or states in which services are performed for the *provider*/*participating provider's* facility/program status (organizations)
- *Accreditation* currently accepted by Beacon for organizations* (currently TJC, *CARF*, *COA*, HFAP, AAAHC, NIAHO, CHAP, and AOA)
- Clinical privileges in good standing at the institution designated as the primary admitting facility, with no limitations placed on the ability to independently practice in his/her specialty (individual practitioners)
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline, or licensure (individual practitioners)
- Current specialty board certification, if indicated on the application (individual practitioners)
- A copy of a current Drug Enforcement Agency (DEA) certificate and/or Controlled Dangerous Substance (CDS) Certificate where applicable (individual practitioners)
- No adverse professional liability claims which result in settlements or judgments paid by or on behalf of the *provider*/*participating provider* which disclose an instance of, or pattern of, behavior which may endanger *members*
- Good standing with state and federal authorities and programs (organizations)
- No exclusion or sanctions from government-sponsored health benefit programs (e.g., Medicare/Medicaid) (individual practitioners and organizations)
- Current specialized training as required for certain levels or areas of specialty care (individual practitioners)
- Malpractice and/or professional liability coverage in amounts consistent with Beacon's *policies and procedures* (individual practitioners and organizations)
- An appropriate work history for the *provider's*/*participating provider's* specialty (individual practitioners)

Changes or updates to any of the above noted information is subject to re-verification from primary sources during the recredentialing process, or at the time of notice of such a change or update from the *participating provider*. Additionally, *providers/participating providers* must have:

- No adverse record of failure to follow Beacon's *policies and procedures* or quality management activities
- No adverse record of provider actions that violate the terms of the *provider agreement*
- No adverse record of indictment, arrest or conviction of any felony or any crime indicating potential or actual *member* endangerment
- No criminal charges filed relating to the *participating provider's* ability to render services to *members*
- No action or inaction taken by *participating provider* that, in the sole discretion of Beacon, results or may result in a threat to the health or well-being of a *member* or is not in the *member's* best interest

Site Visits

In addition and as part of credentialing or recredentialing, Beacon may conduct a structured site visit of *provider's*/*participating provider's* offices/locations. Site visits include, but may not be limited to, an evaluation using the Beacon site and operations standards and an evaluation of clinical recordkeeping practices against Beacon's standards.

The current Beacon site visit tool is available for review on the *website*. As the site visit tool is subject to modification without notice, *participating providers* are encouraged to check the *website* for the most current site visit tool prior to scheduled site visits.

When applicants meet established credentialing criteria but are not accredited by a recognized accrediting body, the Credentialing staff may obtain a copy of the state site visit (where applicable) or request that a structured site visit be scheduled and completed. If the state site visit is accepted, the Credentialing staff will forward for Medical Director Approval. If a structured site visit is needed, the request for a site visit is forwarded to the appropriate staff. Results of the structured site visit are returned to the Credentialing staff for review and determination of status. (Refer to Policy *CR 201 –Facility/Organization Site Visit*). **Exceptions:** The organization is not required to conduct a site visit if the provider is in a rural area, as defined by the U.S. Census Bureau, and the state or CMS has not conducted a site review.

Updates

Providers/*participating providers* are required to report material changes to information included in credentialing and/or recredentialing applications submitted to Beacon. Except as noted below, all such changes must be reported in writing within the time period provided for in the provider agreement, but not to exceed 10 calendar days of the *provider/participating provider* becoming aware of the information. Failure to comply may result in immediate termination of network participation status. The following is a list (not exhaustive) of examples of the types of material changes for which the above report is required:

- Any action against licenses, certifications, registrations, and/or *accreditation* status*
- Any legal or government action initiated that could materially affect the rendering of services to *members*
- Any legal action commenced by or on behalf of a *member*
- Any initiation of bankruptcy or insolvency proceedings, whether voluntary or involuntary
- Any other occurrence that could materially affect the rendering of services to *members*
- Discovery that a claim, suit or criminal or administrative proceeding is being brought against the *provider*/*participating provider* relating to the provider's delivery of care (i.e., a malpractice suit), compliance with community standards and/or to applicable laws, including but not limited to any action by licensing or *accreditation* entities and/or exclusions from a government-sponsored health benefit program (e.g., Medicare/Medicaid)

* The suspension, revocation, expiration and/or voluntary surrender of professional license/certification, DEA certificate, CDS certificate, and/or board certification must be reported within five calendar days of the effective date of the action. (Contact Beacon to coordinate the transition of members to the care of other participating providers where licensure/certification no longer meets Beacon's credentialing/recredentialing standards and/or requirements pursuant to state and/or federal laws regarding the provision of services.)

Note: If a participating provider moves to or expands their practice and/or operations into another state, a copy of the participating provider's license/certification and malpractice/professional liability coverage is required in order to complete primary source verification and credential the participating provider to treat Beacon's members in another state.

Expiration, non-renewal and/or decrease in required malpractice or professional liability coverage must be reported 30 days prior to such change in coverage.

Any changes in demographic information or changes in practice patterns, such as change of services and/or billing address, name change, coverage arrangements, tax identification number, hours of operation, and/or changes in ownership, must be provided to Beacon in advance of such changes. Beacon must receive 60 days' advance notice of any new programs or services offered by a facility provider in order to allow for completion of the credentialing process prior to provision of services to *members*.

Changes in ownership and/or management of *participating providers* may require negotiation and execution of consent to assignment and assumption agreements as related to *provider agreements* and the parties to provider agreements.

Delegation

Should Beacon, in its sole discretion, elect to delegate any credentialing and/or recredentialing activities to a participating provider, such delegation is subject to all applicable policies and procedures, *state* and federal laws, rules and/or regulations, *accreditation* standards to which Beacon is or may be subject, and any client and/or government program specific requirements. Reference to possible delegation herein in no way obligates or requires Beacon to consider delegation of any credentialing and/or recredentialing activities.

Chapter 3

Quality Management Programs

3.1. Quality Management Program Overview

3.2. Program Principles

3.3. Provider Role

3.4. Quality Monitoring

3.5. Clinical Practice Guidelines

3.6. HEDIS FUH, AMM, IET and ADD Behavioral Health Performance Measures

3.7. Communication between Outpatient Behavioral Health Providers, PCP's or Other Physicians

3.8. Communication between Inpatient/Diversionary Providers, PCPs or Other Outpatient Physicians

3.9. Reportable Adverse Incidents, Quality of Care Concerns and Other Reportable Events

3.10. Emergency, Urgent and Routine Member Accessibility to Behavioral Health Services

3.11. Minimum Standards for Appointment Accessibility

3.1. Quality Management Program Overview

PROGRAM DESCRIPTION

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 manual.
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3.2. Program Principles

- Continually evaluate the effectiveness of services delivered to health plan members
- Identify areas for targeted improvements
- Develop QI action plans to address improvement needs
- Continually monitor the effectiveness of changes implemented, over time

PROGRAM GOALS AND OBJECTIVES

- Improve the healthcare status of members
- Enhance continuity and coordination among behavioral health care providers and between behavioral health care and physical health care providers
- Establish effective and cost-efficient disease management programs, including preventive and screening programs, to decrease incidence and prevalence of behavioral health disorders
- Ensure members receive timely and satisfactory service from Beacon and network providers
- Maintain positive and collaborative working relationships with network practitioners and ensure provider satisfaction with Beacon services
- Responsibly contain healthcare costs

3.3. Role of Participating Providers

Participating practitioners/providers are informed about the QMP via the Beacon Provider Manual, 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.

Cooperation with QI activities

Practitioner contracts specify that practitioners cooperate with the organization's QI activities to improve the quality of care and services and member experience. Cooperation includes collection and evaluation of data and participation in the organization's QI programs. Timely response to medical records requests is critical to our review and resolution of potential quality of care concerns.

Beacon Provider Stakeholder Committee

Beacon maintains a Provider Stakeholder Committee that reports up to the Corporate Quality Committee. This committee is a forum for participating network provider stakeholders to have insight and input into the Beacon Clinical (UM and CM) and Quality Management (QM) Programs. This committee is responsible for annual review of materials with provider network including clinical criteria and clinical practice guidelines. Providers may contact Beacon for more information on how to participate on the Provider Stakeholder Committee by emailing Beacon Provider Relations at Miami_Partners@Beaconhealthoptions.com (Florida or South Carolina) or SoutheastServiceCenterPR@Beaconhealthoptions.com (Illinois or Kentucky).

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. Providers should make resources available to members who require culturally, linguistically, and/or disability competent care, such as, but not limited to, disability and language lines. Additionally, Beacon's provider network will not call, direct, urge or attempt to persuade potential enrollees to enroll with any health plan based on financial or any other interest of the provider. In addition, providers will not offer anything of value to persuade potentially new members to select them as their provider.

3.4. Quality Performance Indicator Development and Monitoring Activities

A major component of the quality management process is the identification and monitoring of meaningful company-wide 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 manual, include serious reportable events (SREs) as defined by the National Quality Forum (NQF) and Beacon, and Trending Events (TEs)

3.5. Service Availability and Access to Care

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

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

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

3.6 Clinical Practice Guidelines

Beacon reviews and endorses clinical practice guidelines on a regular basis to support providers in making evidence-based care treatment decisions on a variety of topics. The most up-to-date, endorsed, clinical practice guidelines (CPGs) are posted on the Beacon website.

https://www.beaconhealthoptions.com/providers/beacon/handbook/clinical-practice-guidelines/

Included are those that have been developed or updated within the past two years and represent the best clinical information we have at this time. Other clinical practice resources, while not considered current, still contain information that continues to be clinically relevant. For example, some of the guidelines may recommend specific treatment interventions without adequately addressing the sufficiency of the evidence to support the recommendation. Continued use of the guidelines is warranted because resultant positive clinical contribution outweighs the fact that the summaries of the supporting research may have lacked adequate transparency related to the process of ranking the studies necessary to meet today's standards of guideline development.

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

The Beacon Scientific Review Committee (SRC) reviews and/or updates each guideline at least every two years. In addition, if the original source of the guideline publishes an update or makes a change, the SRC will initiate additional review of the guideline prior to the two-year review cycle. Updates/changes are then presented to Beacon's Corporate Medical Management Committee (CMMC) for final approval.

Additionally, each year, Beacon measures providers' adherence to at least three (3) Clinical Practice Resources. Beacon has chosen the following two adult-focused and one child-focused Clinical Practice Resources for national measurement, unless otherwise required by contract. Beacon will review a portion of its members' medical records using the tool posted on the Beacon website. Questions were developed from the resources. **As Beacon providers, you are expected to ensure your standards of practice align with the endorsed clinical practice guidelines.**

3.7. Healthcare Effectiveness Data and Information Set (HEDIS®)

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

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

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

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

1. Effectiveness of Care
2. Access and Availability
3. Utilization and Relative Resource Use
4. Measures Collected Using Electronic Clinical Data Systems (ECDS)
5. Experience of Care
6. Health Plan Descriptive Information

A brief description of these measures:

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

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

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

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

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

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

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

1. Follow-up after Hospitalization for Mental Illness

Best practice for a member aged six or older to transition from acute mental health treatment to the community is an appointment with a licensed mental health practitioner (outpatient or intermediate treatment) within seven and/or 30 calendar days of discharge.
For this measure, *NCQA* requires organizations to substantiate by documentation from the member's health record all nonstandard supplemental data that is collected to capture missing service data not received through claims, encounter data, laboratory result files, and pharmacy data feeds. Beacon requires proof-of-service documentation from the member's health record that indicates the service was received. All proof-of-service documents must include all the data elements required by the measure.

Data elements included as part of the patient's legal medical record are:

- Member identifying information (name and DOB or member ID
- Date of service
- DSM diagnosis code
- Procedure code/Type of service rendered
- Provider site/facility
- Name and licensure of mental health practitioner rendering the service
- Signature of rendering practitioner, attesting to the accuracy of the information

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

- Inpatient facilities need to:
    - Use accurate diagnoses when submitting claims for inpatient treatment. If the diagnosis on admission is a mental health diagnosis but subsequent evaluation during the stay confirms that the primary diagnosis is substance use, please use the substance use *diagnosis* on the claim submitted at discharge.
- Ensure that discharge planners educate patients about the importance of aftercare for successful transition back to their communities.
- Ensure that follow-up *visits* are within seven calendar days of discharge.
    - **Note:** It is important to notify the *provider/participating providers* that the appointment is post hospital discharge and that an appointment is needed in seven calendar days.
- Ensure that the appointment was made with input from the patient. If the member has a pre-existing provider and is agreeable to going back to that provider, schedule the appointment with that provider. If not, the location of the outpatient provider or PHP, IOP or other alternative level of care, must be approved by the member, be realistic and feasible for the member to keep that appointment.

Outpatient providers/participating providers need to make every attempt to schedule appointments within seven calendar days for members being discharged from inpatient care. Providers/participating providers are encouraged to contact those members who are "no show" and reschedule another appointment.

Beacon requires providers to assist in the coordination of care with Beacon's case management department.

Beacon requires inpatient hospitals to ensure every member discharging from a psychiatric unit have a scheduled follow up appointment within 7 days of discharge with a behavioral health provider. Additionally, Beacon requires outpatient behavioral health providers (i.e., CMHC, groups, solo practitioner) have appointment availability and access to schedule an appointment within 7 days of discharge for any inpatient hospital discharging a member within their catchment.

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

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

- **Initiation of AOD Use Treatment**: The percentage of adults diagnosed with AOD Use who initiate treatment through either an inpatient AOD admission or an outpatient service for AOD from a substance use provider AND an additional AOD service within 14 calendar days.

- **Engagement of AOD Treatment**: An intermediate step between initially accessing care and completing a full course of treatment. This measure is designed to assess the degree to which the members engage in treatment with two additional AOD services within 30 calendar days after initiation phase ends. The services that count as additional AOD services include IOP, Partial Hospital, or outpatient treatment billed with CPT-4 or revenue codes associated with substance use treatment.

3. Antidepressant Medication Management (AMM)

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

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

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

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

- **Initiation Phase**: For children, 6-12 years of age, newly prescribed ADHD medication best practice requires a follow up visit with a prescriber within 34 days of receiving the medication.

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

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

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

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

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

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

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

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

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

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

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

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

This measure identifies children and adolescents who are on two or more concurrent antipsychotic medications. Multiple concurrent use of antipsychotic medications is not best practice nor approved by the FDA. While there are specific situations where a child or adolescent requires concurrent medications, the risk/benefit of the treatment regime must be carefully considered and monitoring in place to prevent adverse outcome.

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

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

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

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

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

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

- **ECDS Coverage**. The percentage of members 12 and older with a diagnosis of major depression or dysthymia, for whom a health plan can receive any electronic clinical quality data.

- **Follow-Up PHQ-9**. The percentage of members who have a follow-up PHQ-9 score documented within the five to seven months after the initial elevated PHQ-9 score.

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

- **Depression Remission**. The percentage of members who achieved remission within five to seven months after the initial elevated PHQ-9 score.
- **Depression Response**. The percentage of members who showed response within five to seven months after the initial elevated PHQ-9 score.

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

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

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

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

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

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

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

Here is the complete list of HEDIS Behavioral Health measures:

Effectiveness of Care:

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

Other Domains:

Access and Availability

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

Utilization/Relative Resource Use - Utilization

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

Health Plan Descriptive Information

- **BCR:** Board Certification

Electronic Clinical Data Systems

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

3.8. Continuity and Coordination of Care

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

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

3.9. Screening Programs

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

Beacon offers many screening tools and programs available at no cost:

- **PCP/ Provider Toolkit:** http://pcptoolkit.beaconhealthoptions.com/
- **Depression Screening Program** (PDF)
- **Comorbid Mental Health and Substance Use Disorder Screening Program** (PDF)
- Use screening tools at the first visit and repeat at regular intervals as clinically indicated to identify potential symptoms that may need further evaluation.
- Depression
- Patient Health Questionnaire 9 (PHQ-9) is a brief, multi-purpose tool for assessing depression, and is available in **English**, **Spanish**, and a variety of other languages in **Beacon's PCP/ Provider Toolkit**.
- When assessing for depression, remember to rule out bipolar disorders; you may choose to use the **Mood Disorder Questionnaire (MDQ)**.
- Suicide
- Beacon endorses the National Action Alliance for Suicide Prevention's **Recommended Standard Care for People with Suicide Risk**, which screens individuals for suicide and includes a list of screening tools in the Appendix.
- Comorbid issues
- Remember to screen for possible mental health disorders when a diagnosis of a substance use disorder is present and conversely to screen for a potential substance use disorder when a mental health disorder is present.

The **CRAFFT Screening Interview** (PDF) assesses for substance use risk specific to adolescents. Learn more about Beacon's Depression Screening Program and Comorbid Screening Program at the attached links.

3.10. 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 *manual* 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.

3.11. 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*

3.12. Emergency, Urgent, and Routine Member Accessibility to Behavioral Health Services

EMERGENCY SERVICES

Emergency services, necessary to screen and stabilize a member are authorized without prior approval, when a prudent layperson, acting reasonably, and believes that an emergency behavioral health condition exists or an authorized representative, acting on behalf of Beacon, has authorized the provision of emergency services. Beacon shall at all times, authorize an emergency psychiatric evaluation as per the members' benefit plan.

3.13. Minimum Standards for Appointment Accessibility

MEDICARE PERFORMANCE GOALS:

Upon receipt of the request by the Beacon clinical staff or the network practitioner/provider:

- Members receive care for emergency and urgently needed services immediately
- Services that are not emergency or urgently needed, but in need of medical attention, within one week
- Routine and Preventive care, within 30 days

FLORIDA MEDICAID PERFORMANCE GOALS:

- The Managed Care Plan shall ensure that appointments for medical services and behavioral health services are available on a timely basis:
- Appointments for urgent medical or behavioral health care services shall be provided:
    - Within forty-eight (48) hours of a request for medical or behavioral health care services that do not require prior authorization.
    - Within ninety-six (96) hours of a request for medical or behavioral health care services that do require prior authorization.
- Appointments for non-urgent care services shall be provided:
    - Within seven (7) days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment.
    - Within fourteen (14) days for initial outpatient behavioral health treatment.
    - Within fourteen (14) days of a request for ancillary services for the diagnosis or treatment of injury, illness, or other health condition.
    - Within thirty (30) days of a request for a primary care appointment.
    - Within sixty (60) days of a request for a specialist appointment after the appropriate referral is received by the specialist.
- Quarterly, the Managed Care Plan shall review a statistically valid sample of PCP, specialist, and behavioral health offices' average appointment wait times to ensure services are in compliance with this subsection (a) above, and report the results to the Agency as specified in Section XVI.,

Reporting Requirements, and the Managed Care Plan Report Guide. (42 CFR 438.206(c)(1)(iv),(v), and (vi))

- The Managed Care Plan shall ensure that early intervention services are provided no later than thirty (30) days from the date the IFSP was completed for children enrolled in the Early Steps Program

FLORIDA HEALTHY KIDS (FHK)

- Insurer shall require network providers to offer hours of operation and appointment times that are no less than the hours of operation and appointment times offered to commercial enrollees.
- Insurer shall provide timely treatment for Enrollees in accordance with the following standards:
    - Emergency care shall be provided immediately.
    - Urgently needed care shall be provided within twenty-four (24) hours.
    - Routine care shall be provided within seven (7) Calendar Days of the Enrollee's request for services.
    - Well-child visits, as recommended by the American Academy of Pediatrics, shall be provided within four (4) weeks of the Enrollee's request.
    - Follow-up care shall be provided as medically appropriate

COMMERCIAL AND HEALTH EXCHANGE PERFORMANCE GOALS:

Upon receipt of the request by the Beacon clinical staff or the network practitioner/provider:

- Members receive care for non-life threatening emergencies within 6 hours
- Members receive urgent care within 48 hours
- Members receive an appointment for a routine office visit within 10 business days

ACCESSIBILITY

Each provider shall provide covered services during normal business hours. Covered services shall be available and accessible to members, including telephone access, on a 24-hour, seven-day per week basis, to advise members requiring urgent or emergency services.

Specialists shall arrange for appropriate coverage by a participating provider when unavailable due to vacation, illness or leave of absence. As a participating Beacon provider, you must be accessible to members 24 hours a day, seven days a week. The following are acceptable and unacceptable phone arrangements for contacting physicians after normal business hours.

Acceptable:

1. Office phone is answered after hours by an answering service. All calls answered by an answering service must be returned within 30 minutes.
2. Office phone is answered after normal business hours by a recording in the language of each of the major population groups serviced, directing the patient to call another number to reach another provider designated to you. Someone must be available to answer the designated provider's phone. Another recording is not acceptable.
3. Office phone is transferred after office hours to another location where someone will answer the

phone and be able to contact another designated medical practitioner.

Unacceptable:

1. Office phone is only answered during office hours.
2. Office phone is answered after hours by a recording, which tells the patients to leave a message.
3. Office phone is answered after hours by a recording that directs patients to go to an emergency room for any services needed.
4. Returning after-hours calls outside of 30 minutes

EMERGENCY PRESCRIPTION SUPPLY

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a PA, either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the vendor drug program formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

3.14. 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 and investigation 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 utilizes a model of Potential Quality of Care (PQOC) Concerns including Serious Reportable Events (SREs) and Trending Events (TE). 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 interchangeably or may have a specific definition based on state requirements.

Serious Reportable Events (SRE) include, but are 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 National Credentialing Committee (NCC) based on the findings of an investigation or any failure to cooperate with a request for information pursuant to an adverse incident investigation.

3.15. Professional Review/Fair Hearing Process

Individual p*roviders*/*participating providers*, where required by applicable law, may request a second level of *appeal*/a *fair hearing* when the PAC denies credentialing or recredentialing, issues a sanction, or recommends termination of participation status of the *provider* from the Beacon provider network, where such denial, sanction, or recommendation is based on quality of care issues and/or issues related to professional competence or professional conduct. Information about the *fair hearing* process is located in the *appeals* section of this *manual.*

3.16. Quality Improvement Activities/Projects

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

- Monitoring of clinical quality indicators
- Review and analysis of the data from indicators
- Identification of opportunities for improvement
- Prioritization of opportunities to improve processes or outcomes of behavioral health care delivery based on *risk assessment*, ability to impact performance, and resource availability
- Identification of the affected population within the total membership
- Identification of the measures to be used to assess performance
- Establishment of performance goals or desired level of improvement over current performance
- Collection of valid data for each measure and calculation of the baseline level of performance
- Thoughtful identification of interventions that are powerful enough to impact performance

- Analysis of results to determine where performance is acceptable and, if not, the identification of current barriers to improving performance

3.17. Experience Surveys (formerly known as Satisfaction Surveys)

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

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

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

3.18. Provider Quality Management

Beacon's Provider Quality department offers a collaborative and data informed approach to working with providers. Clinical Provider Strategy bridges a key gap in many managed care approaches, working innovatively to increase Beacon's ability to meet goals through collaborating with providers on shared outcomes informed by provider facing reports using aligned data definitions. Providers who participate in the program are required to meet with Beacon on a quarterly basis at a minimum.

Provider Quality Managers (PQM) serve as a direct contact for a subset of Beacon providers known as Strategic Providers. Provider Quality identifies Strategic Providers based on market volume, with consideration given to providers of specialty services that improve quality and/or access to care for target populations.

The primary goals and objectives of the Provider Quality department are:

1. **Transform provider relationships to improve health outcomes.** As the strategic connector between Beacon and providers, PQMs provide clinical support and technical assistance, enabling providers to focus resources on patient care and quality initiatives rather than administrative processes.
2. **Drive clinical and quality improvements.** Compare clinical, quality, and financial results against historical provider data and the market aggregate, highlighting opportunities to improve performance over time.
3. **Promote innovation through new program development.** Collaborate with providers to identify best practices and implement new treatment approaches to enhance clinical programming.

3.19. Member Complaints and Grievances

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

Chapter 4

Provider and Member Complaint and Appeals Process

4.1. Complaints/Grievances

4.2. Provider Disputes

4.3 Appeals of Complaint/Grievance Resolutions

4.4. Clinical Appeals Processes

4.1. Complaints/Grievances

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

Beacon Provider Services representatives are available to assist providers with any issues or concerns regarding the administration of services. Most issues and complaints can be resolved promptly by calling Customer Care at the Behavioral Health number listed on the member's health plan identification card between the hours of 8 a.m. ET to 8 p.m. ET, Monday through Friday. Contracted providers may also register formal complaints at any time, to express dissatisfaction with a Beacon policy, procedure, administrative function or for any other reason a provider deems appropriate. Complaints, unrelated to claims, may be reported by phone or in writing, within 45 days of the occurrence prompting the complaint. For claims complaints, please refer to Provider Disputes section in this Manual.

To register a complaint by phone, contact the Customer Care Team at the Behavioral Health number listed on the member's health plan identification card. To register a complaint in writing, send the written request to: Beacon Health Options Attention: Grievance & Appeals Department P.O. Box 1872 Hicksville, NY 11802-1872. All complaints are acknowledged within 3 business days of receipt, and reviewed confidentially by the Grievance and Appeals Department, using applicable statutory, regulatory and contractual provisions. Most complaints may be resolved immediately. However, if an immediate resolution is not possible, the resolution will be made as expeditiously as is possible, but will not exceed ninety (90) days of receipt of the complaint. The resolution of the complaint is communicated in writing within 3 business days of the resolution.

If a plan member complains or expresses concerns regarding Beacon's procedures or services, health 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 Customer Care team at the Behavioral Health number listed on their health plan identification card to file a member complaint.

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

Providers may register their own complaints/grievances and may also register complaints/grievances on a member's behalf. Members, or their guardian or representative on the member's behalf, may also register complaints/grievances. Contact us to register a complaint/grievance either via email at ComplaintsMSC@beaconhealthoptions.com or by calling the Behavioral Health number listed on their health plan identification card.

If the complaint/grievance is determined to be urgent (ACHA), the resolution is communicated to the member and/or provider verbally within 48 hours or sooner. If the complaint/grievance is determined to be non-urgent, Beacon's Customer Care Team will resolve to the best of their abilities and advise the member of the resolution via phone.

For both urgent and non-urgent complaints/grievances, the resolution letter informs the member or member's representative to contact Beacon's Ombudsperson in the event that he/she is dissatisfied with Beacon's resolution.

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

4.2. Provider Disputes

Beacon is committed to the timely resolution of all provider disputes relative to claims payment. Any disagreement regarding the processing, payment or non-payment of a claim is considered a Provider Dispute. To file a Provider Dispute, providers may contact Customer Care team, at the Behavioral Health number listed on the member's health plan identification card, or send the request for review in writing, along with any supporting documentation to the address below: Beacon Health Options Attention: Grievance & Appeals Department P.O. 1872 Hicksville NY 11802-1872. Provider Disputes must be received within 365 days of the date of payment or denial of the claim. All provider disputes will be reviewed by the Grievance and Appeals Department, and the outcome will be communicated in writing within 45 business days from receipt of the Provider Dispute

4.3 Appeals of Complaint/Grievance Resolutions

If the member or member representative is not satisfied or does not agree with Beacon's complaint/grievance resolution, he/she has the option of requesting an appeal with Beacon. An appeal is a written or oral request for review of an action/determination made by Beacon.

The member or member representative has 30 calendar days [depending on state regulation] after receipt of notice of the resolution to file a written or verbal appeal.

Appeals of complaint/grievance resolutions are reviewed by Beacon's Peer Review Committee and assigned to an account manager from another health plan to review and make a determination. This determination will be made in a time frame that accommodates the urgency of the situation but no more than 10 business days. Notification of the appeal resolution will be telephonic on the same day of the resolution for urgent complaints/grievances. Written notification will be made within 1-2 business days of the appeal decision (time frames according to state regulation).

REQUEST FOR RECONSIDERATION OF ADVERSE DETERMINATION

If a plan member or member's provider disagrees with an expedited or urgent utilization review decision issued by Beacon, the member, his/her authorized representative, or the provider may request reconsideration. Please call Beacon's Ombudsperson associated with the health plan promptly upon receiving notice of the denial for which reconsideration is requested. Please refer to the health plan specific Contact Information sheet for the Ombudsperson phone number.

When reconsideration is requested, a physician advisor (PA), who has not been party to the initial adverse determination, 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 the reconsideration, he or she may file an appeal.

4.4. Clinical Appeals Processes

OVERVIEW

A plan member and/or the member's appeal representative or provider (acting on behalf of the member)

may appeal an adverse action/adverse determination. Both clinical and administrative denials may be appealed. Denials for non-covered benefits cannot be appealed. If the member is still receiving the services that are under appeal review and the services are covered services, the services may continue until a decision is made on the appeal. Appeals may be filed either verbally, or in writing mailed to:

Beacon Health Options

P.O. Box 1872

Hicksville, NY 11802-1872

Appeal policies are made available to members and/or their appeal representatives upon request. Appeal rights are included in all action/adverse determination notifications.

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

Peer Review

A peer review conversation may be requested at any time by the treating provider and may occur prior to or after an adverse action/adverse determination. Beacon utilization review (UR) clinicians and peer review physicians are available daily to discuss denial cases by phone.

Urgency of Appeal Processing

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

Appeals Process Detail

This section contains detailed information about the appeal process for [health plan] members, in two tables: Table 4-1: Expedited Clinical Appeals; Table 4-2: Standard Clinical Appeals

Each table illustrates:

- How to initiate an appeal
- Resolution and notification time frames for expedited and standard clinical appeals, at the first, second (if applicable), and external review levels.

TABLE 4-1: EXPEDITED CLINICAL APPEALS

Expedited Clinical Appeals		
Level 1 Appeal	**Level 2 Appeal**	**External Review**
Members, their legal guardian, or their authorized representative have up to 30-60 calendar days for Medicaid; 180 calendar days for commercial; 60 calendar days for Medicare/Duals after receiving notice of an adverse action in which to file an appeal. If the member designates an authorized representative to act on his or her behalf, Beacon will attempt to obtain a signed and dated Authorization of Representative Form. Both verbal and written communication can take place with a provider who initiated the expedited appeal or with the individual who the member verbally designated as his or her representative. A Beacon PA, who has not been involved in the initial decision, reviews all available information and attempts to speak with the member's attending physician. A decision is made within 24-72 hours, depending on line of business and state regulations of initial request. Written notification of the decision is sent to the provider and the member within 1-2 business days after the appeal decision. Throughout the course of an appeal the member shall continue to receive services without liability for services previously authorized by Beacon, as long as all of the following criteria are met: The appeal was filed in a timely fashion The appeal involved the termination, suspension, or reduction of a previously authorized course of treatment The services were ordered by an authorized provider The original period covered by the authorization has not expired The member requested an extension of the benefits	n/a	External reviews for Medicaid Members Members or their representatives may request an expedited State Fair Hearing with the state office associated with the member's Medicaid plan. Please refer to the health plan-specific Contact Information sheet at the end of this manual for the address and phone number of the State Fair Hearing office. For assistance in filing a request for a State Fair Hearing with the state office associated with the member's Medicaid plan on your behalf, you may contact Beacon's Member Services Department through the plan's dedicated phone line. Please refer to the health-plan specific Contact Information sheet at the end of this manual. Please note at this fair hearing, members may represent him/herself or appoint someone to represent him/her. Please refer to the health plan-specific Contact Information sheet at the end of this manual for the number of business days a decision will be made after Beacon receives the request for the State Fair Hearing. External Reviews for Commercial Members Members or their representatives

		may request an expedited external review by an Independent Review Organization (IRO). The member, representative or provider must complete Beacon's internal appeal process before requesting an IRO unless the appeal involves a life-threatening condition.
Contact Information Appeal requests can be made by calling Beacon's Appeals Coordinator. Please refer to the health plan-specific addendum for contact information		Contact Information For Medicaid Members Please refer to the health plan-specific Contact Information sheet at the end of this manual for the address and phone number of the State Fair Hearing office. For Commercial Members Please contact the state's Independent Review Organization. Please refer to the health plan-specific Contact Information sheet for the address and phone number of the Independent Review Organization.

Please note that providers may act as a member's Authorized Representative.

TABLE 4-2: STANDARD CLINICAL APPEALS

Standard Clinical Appeals		
Level 1 Appeal	**Level 2 Appeal**	**External Review**
Members, their legal guardian, or their Authorized Representative have up to 30-60 calendar days for Medicaid; 180 calendar days for Commercial; 60 calendar days for Medicare/Duals after receiving notice of an adverse action in which to file an appeal. If the member designates an	N/A	**External Reviews for Medicaid Members** Members or their representatives may request an expedited state fair hearing with the state. Please refer to the health plan-specific Contact Information sheet at the end of this manual. For assistance in filing a request for a state fair

Authorized Representative to act on his or her behalf, Beacon will attempt to obtain a signed and dated Authorization of Representative Form. Both verbal and written communication can take place with a provider who initiated the appeal or with the individual who the member verbally designated as his or her representative. A Beacon PA, who has not been involved in the initial decision, reviews all available information. A decision is made within 30 calendar days of initial request, (depending on line of business and state regulations) for standard appeals. If the appeal requires review of medical records, the member's or AMR's signature is required on an Authorization to Release Medical Information Form authorizing the release of medical and treatment information relevant to the appeal. If the medical record with Authorization to Release Medical Information Form is not received prior to the deadline for resolving the appeal, a resolution will be rendered based on the information available. The provider must submit the medical chart for review. If the chart is not received, a decision is based on available information.		hearing with the state on your behalf, you may contact Beacon's Member Services. Please refer to the health plan specific addendum for contact information. You may also request assistance by sending a written request to Beacon's Appeals Coordinator. Please refer to the health plan specific Contact Information sheet for the phone number of the Appeals Coordinator. Please note at this fair hearing, members may represent themselves or appoint someone to represent them. A decision will be made within a certain number of business days of the date the Department received the request for the state fair hearing. Please refer to the health plan-specific Contact Information sheet for the number of business days associated with State Fair Hearings. **External Reviews for Commercial Members** Members or their representatives may request an external review by an Independent Review Organization. The member, representative or provider must complete Beacon's internal appeal process before requesting an IRO.
Contact Info: Appeal requests can be made by calling Beacon's Appeals Coordinator. Please refer to the health plan specific addendum		Contact Info: **For Medicaid Members** Please contact your state's State Fair Hearings office. Please refer to the health

for contact information.		plan specific Contact Information sheet for the address and phone number of the State Fair Hearings office. **For Commercial Members** Please contact the state's Independent Review Organization. Please refer to the health plan-specific Contact Information sheet at the end of this manual for the address and phone number of the Independent Review Organization.

Please note that providers may act as a member's Authorized Representative.

Chapter 5

Member Eligibility

5.1. Member Eligibility

5.2. Disenrollment

5.3. Member Rights and Responsibilities

5.4. Fraud Reporting

5.1. Member Eligibility

Establishing member eligibility for benefits and obtaining an authorization before treatment is essential for the claims payment process. Your state's Health and Human Services Department is responsible for determining Medicaid. Therefore, if you have Medicaid, please contact your state's Medicaid program to determine eligibility. If you have a commercial insurance, please contact Beacon Health Strategies' Member Services to determine your eligibility. To determine whether you are eligible for Medicare, please visit Medicare.gov or call Beacon's Member Services Department.

5.2. Disenrollment

Your state determines who is eligible for your state's Medicaid program. Your state's Health and Human Services Department (name varies by state) is solely responsible for determining if and when a member is disenrolled and will make the final decision. Under no circumstances can a provider/practitioner take retaliatory action against a member due to disenrollment from either the provider/practitioner or a plan.

There may be instances when a PCP feels that a member should be removed from his or her panel. Beacon requests you contact the member's medical health plan to notify of such requests so that they may arrange educational outreach with the member. All notifications to remove a patient from a panel must be made in writing; contain detailed documentation; and must be directed to the member's medical health plan.

Upon receipt of such request, staff may:

- Interview the provider/practitioner or his/her staff who are requesting the disenrollment, as well as any additional relevant providers/practitioners
- Interview the member
- Review any relevant medical records

Examples of reasons a PCP may request to remove a patient from their panel could include, but not be limited to:

- a member is disruptive, unruly, threatening, or uncooperative to the extent that the member seriously impairs the provider's ability to provide services to the member, or to other members and the member's behavior is not caused by a physical or behavioral condition; or
- if a member steadfastly refuses to comply with managed care, such as repeated emergency room use combined with refusal to allow the provider to treat the underlying medical condition. A PCP should never request that a member be disenrolled for any of the following reasons:
    - An adverse change in the member's health status or utilization of services that is medically necessary for the treatment of a member's condition
    - On the basis of the member's race, color, national origin, sex, age, disability, political beliefs or religion

5.3. Member Rights and Responsibilities

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

5.4. Fraud Reporting

REPORTING FRAUD WASTE OR ABUSE BY A PROVIDER, CLIENT OR MEMBER

MEDICAID MANAGED CARE

Do you want to report waste, abuse, or fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other healthcare providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary
- Not telling the truth about a medical condition to get medical treatment
- Letting someone else use their Medicaid ID
- Using someone else's Medicaid ID
- Not telling the truth about the amount of money or resources he or she has to get benefits

To report waste, abuse, or fraud, choose one of the following:

- You may report directly to Beacon at our Compliance Hotline at 1-888.293-3027 and speak to one of our senior Customer Care representatives. .
- You may contact your state's Health and Human Services Department and ask to speak with the fraud investigator. (to validate with SIU team)

To report waste, abuse or fraud, gather as much information as possible. When reporting about a provider (a doctor, counselor, etc.) include:

  - Name, address, and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility, if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened

- When reporting about someone who gets benefits, include:
  - The person's name
  - The person's date of birth, Social Security Number, or case number if you have it
  - The city where the person lives
  - Specific details about the waste, abuse or fraud

Chapter 6

Encounter Data, Billing and Claims

6.1. Claims Submission Timelines

6.2. Claims Submission Process

6.3. Claims Transactions on eServices

Encounter Data, Billing and Claims

Beacon Health Strategies strives to be a partner to providers, ensuring accurate and timely claims processing and payment. To this end, Beacon makes available to providers various tools to assist with claims submission and payment, such as Policy and Procedure manuals describing Beacon's claim guidelines. Intensive internal auditing and quality checks are conducted to ensure compliance with these guidelines. Changes to Beacon policies are communicated via our Beacon bulletin system and can be found in the Provider Tools section. We encourage you to check our website frequently for any changes to policies.

6.1. Claims Submission Timelines

- Original claims must be received in house at Beacon within 180 days from the date of service for an outpatient service or within 180 days from the discharge date of an inpatient claim. Claims must match the authorization or certification or notification applicable to covered services for which the claim applies to avoid potential delays in processing.
- Resubmissions of denied claims will be treated as original and need to follow the same timeline as original claims.
- Adjustments to paid claims must be received within 180 days from the date of service for an outpatient service or within 180 days from the date of discharge for an inpatient claim.
- Requests for Reconsideration of timely filing that do not meet the waiver criteria must be received within 60 days of the original denial date to be considered.
- Coordination of Benefits -
    - Medicaid Secondary claims must be received within 90 days from the date of the primary payer's Explanation of Payment.
    - Medicare Secondary claims must be received within 180 days from the date of the primary payer's Explanation of Payment.

6.2. Claims Submission Process

Providers submit all institutional/hospital and professional/medical claims electronically. Electronic submission results in fast processing times, high claims approval rates, and fast revenue cycles, while reducing unnecessary administrative time. Electronic claims can be paid in a little as one day. Beacon makes it easy for providers to submit claims electronically, through any of three methods:

- EDI (837 format)
- eServices as primary method or in conjunction with EDI.
- Emdeon claims clearinghouse

Providers without internet access may submit paper claims on CMS1500 or UB04 claim form.

Paper claims and correspondence should be mailed to:

Beacon Health Options

P.O. Box 1870

Hicksville, NY 11802-1870

6.3. Claims Transactions on eServices

Beacon's eServices application is accessible 24/7 to support nearly every provider transaction with Beacon. eServices also supports other claims transactions:

Submit claims directly	View & print claim reports
Submit EDI claims	Resubmit claims immediately
Check claim status	Submit claim adjustments
View & print EOBs	Submit request for reconsideration

eServices save you valuable time, and results in higher approval rates and faster revenue cycles. Register for eServices now.

BEACON IS AN EMDEON PAYER

Beacon accepts Institutional/Hospital and Professional/Medical claims electronically from Emdeon Business Services. For assistance with submitting claims via Emdeon, please contact your Emdeon Customer Support at (800) 845-6592.

EMDEON CLAIMS SUBMISSION

Plan ID	**CMS 1500 Field**	**UB-04 Field**
HEALTH PLAN:		

	Plan ID	**CMS 1500 Field**	**UB-04 Field**
ALL HEALTH PLANS			
Rendering/Attending Provider NPI	n/a	24.J	76

Billing Provider NPI	n/a	33.a	56

BEACON'S EMDEON PAYOR ID IS 43324.

You must use Beacon's Emdeon Payor ID and the member's Health Plan "Plan ID." Using just one or the other will cause claims to REJECT.

BALANCE BILLIING

Participating providers may not balance bill *members* for *covered services* rendered. This means that the *participating provider* may not bill, charge or seek reimbursement or a deposit, from the *member* for *covered services* except for applicable *member expenses*, and non-covered services. *Participating providers* are required to comply with provisions of Beacon's code of conduct where applicable, including, without limitation, cooperation with claims and billing procedures and participation in training and education. *Balance billing* education is provided by Beacon as included in quarterly *Fraud*, Waste, and Abuse provider training.

Chapter 7

Communicating With Beacon Health Strategies

7.1. Transactions and Communications with Beacon Health Strategies

7.2. Electronic Media

7.3. Communication of Member and Provider Information

7.4. Member Eligibility Verification Tools

7.1. Transactions and Communications with Beacon Health Strategies

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

7.2. Electronic Media

To streamline providers' business interactions with Beacon, we offer eServices and email.

On eServices, Beacon's secure web portal supports all provider transactions, while saving providers time, postage expense, billing fees, and reducing paper waste. eServices is completely free to contracted providers and is accessible through www.beaconhealthoptions.com 24/7.

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

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

Click here to register for an eServices account; have your practice/organization's NPI and tax identification number available. The first user from a provider organization or practice will be asked to sign and fax the eServices terms of use, and will be designated as the account administrator unless/until another designee is identified by the provider organization. Beacon activates the account administrator's account as soon as the terms of use are received.

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

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

ELECTRONIC TRANSACTIONS AVAILABILITY (WHEN BEACON IS CLAIMS PAYOR)

Transaction/Capability	Available 24/7 on:		
	eServices at www.beaconhealthoptions.com		EDI at www.beaconhealthoptions.com
Verify member eligibility, benefits and copayment	Yes		Yes (HIPAA 270/271)
Check number of visits available	Yes		Yes (HIPAA 270/271)
Submit outpatient authorization requests	Yes		
View authorization status	Yes		
Update practice information	Yes		
Submit claims	Yes		Yes (HIPAA 837)
Upload EDI claims to Beacon and view EDI upload history	Yes		Yes (HIPAA 837)
View claims status	Yes		Yes (HIPAA 835)
Print claims reports and graphs	Yes		
Download electronic remittance advice	Yes		Yes (HIPAA 835)
EDI acknowledgment & submission reports	Yes		Yes (HIPAA 835)
Pend authorization requests for internal approval	Yes		
Access Beacon's level-of-care criteria & provider manual	Yes		

EMAIL

Beacon encourages providers to communicate with Beacon by email using your resident email program or internet mail application.

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

7.3. Communication of Member and Provider Information

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

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

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

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

Required Notifications

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

Beacon Health Strategies LLC' Provider Database

Type of Information	Method of Notification	
General Practice Info	**eServices**	**Email**
Change in address or telephone number of any service	Yes	Yes
Addition or departure of any professional staff	Yes	Yes
Change in linguistic capability, specialty or program	Yes	Yes
Discontinuation of any covered service listed in Exhibit A of provider's PSA	Yes	Yes
Change in licensure or accreditation of provider or any of its professional staff	Yes	Yes
Appointment Access		
Change in licensure or accreditation of provider or any of its professional staff	Yes	Yes
Change in hours of operation	Yes	Yes
Is no longer accepting new patients	Yes	Yes

Is available during limited hours or only in certain settings	Yes	Yes
Has any other restrictions on treating members	Yes	Yes
Is temporarily or permanently unable to meet Beacon standards for appointment access	Yes	Yes
Other		
Change in designated account administrator for the provider's *eServices* accounts	No*	Yes
Merger, change in ownership, or change of tax identification number (As specified in the PSA, Beacon is not required to accept assignment of the PSA to another entity).	No*	Yes
Adding a site, service or program not previously included in the PSA, remember to specify: a) Location; and b) Capabilities of the new site, service, or program.	No*	Yes

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

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

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

Other Benefits Information

- Benefits do not include payment for healthcare services that are not medically necessary.
- Neither Beacon nor your health plan is responsible for the costs of investigational drugs or devices or the costs of non-healthcare services, such as the costs of managing research or the costs of collecting data that is useful for the research project but not necessary for the member's care.

- Authorization is required for all services except emergency services.

Health Plan Member Identification Cards

Plan members are issued a member identification card. The card is not dated, nor is it returned when a member becomes ineligible.

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

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

7.4. Member Eligibility Verification Tools

Online	Electronic Data Interchange (EDI)
Beacon's **eServices**	Providers with EDI capability can use the 270/271 EDI transaction with Beacon. To set up an EDI connection, or for any questions about EDI, please contact: EDI Helpdesk Phone: (888) 247-9311 from 8 a.m.-6 p.m. ET, Monday through Friday Fax: (866) 698-6032 Email: e-supportservices@beaconhealthoptions.com

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

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

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

Chapter 8

Case Management and Utilization Management

8.1. Case Management

8.2. Utilization Management (UM)

8.3. Medical Necessity and Level-of-Care Criteria

8.4. Utilization Management Terms and Definitions

8.5. Decision and Notification Time Frames

8.1. Case Management

Beacon's Intensive Case Management Program (ICM) is designed to ensure the coordination of care for children and adults at significant clinical risk due to behavioral health conditions and psychosocial factors. The program is designed to promote community tenure, reduce recidivism, improve treatment compliance and facilitate positive outcomes. The program includes assessment, care planning, advocacy and linkage to necessary support and services. Individualized care plans are developed in collaboration with members and their healthcare teams aimed at improving a member's overall functioning. Beacon Case Management is provided by Licensed Behavioral Health Clinicians.

Referrals for ICM are taken from inpatient facilities, outpatient providers, health plan representatives, PCPs, state agencies, members and their families.

Screening criteria for ICM include, but are not limited to, the following:

- Member has a prior history of acute psychiatric, or substance use admissions authorized by Beacon with a readmission within a 60-day period
- First inpatient hospitalization following serious suicide attempt, or treatment for first psychotic episode
- Member has combination of severe, persistent psychiatric clinical symptoms, and lack of family, or social support along with an inadequate outpatient treatment relationship, which places the member at risk of requiring acute behavioral health services
- Presence of a co-morbid medical condition that, when combined with psychiatric and/or substance use issues, could result in exacerbation of fragile medical status
- Adolescent or adult who is currently pregnant, or within a 90-day postpartum period that is actively using substances, or requires acute behavioral health treatment services
- A child living with significant family dysfunction and continued instability following discharge from inpatient or intensive outpatient family services who requires support to link family, providers and state agencies, which places the member at risk of requiring acute behavioral health services
- Multiple family members who are receiving acute behavioral health and/or substance use treatment services at the same time
- Other, complex, extenuating circumstances where the ICM team determines the benefit of inclusion beyond standard criteria

Members who do not meet criteria for ICM may be eligible for Care Coordination. Members identified for care coordination have some clinical indicators of potential risk due to barriers to services, concern related to adherence to treatment recommendations, new onset psychosocial stressors, and/or new onset of co-morbid medical issues that require brief Care Management interventions. Care Coordination will also serve as a resource to inpatient Discharge Planners needing services for members.

In collaboration with participating Medicaid Health Plans of Florida, Beacon supports members through the Healthy Behaviors Program that is funneled through an integrated model of care within the Beacon Case Management Department. The Smoking Cessation Healthy Behaviors track addresses the needs of members who would like to abstain from nicotine. The Substance Use Healthy Behaviors track addresses the needs of the members who would like to abstain from other substances. Members may be referred through any source, including, but not limited to:

- PCP
- Provider
- Family member
- Self

Both tracks have multiple components to address the individualized need of the member from a treatment perspective. In coordination with therapy and possible medication assistance, these members may also be connected to additional resources in the community, such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), when applicable. Once a member completes a phase (3 months in length per phase) in either program, they are eligible for a gift card in a pre-determined amount decided by the participating Medicaid Health Plan.

Involvement in any Beacon Case Management program is voluntary, and verbal consent by the member is required for participation. For further information on how to refer a member to any Case Management services, please refer to the health plan-specific Contact Information sheet.

At any time during a member's involvement with Beacon's Case Management program, if connection to services outside of their covered benefits, such as community resources, is needed the case management team will assist with referrals and connection to those services. The case management team will support coordination between providers and other agencies working with the member that may be outside the scope of their covered benefits or providing services through interagency agreements.

8.2. Utilization Management

Beacon's Utilization Management (UM) program is administered by licensed, experienced clinicians, who are specifically trained in utilization review (UR) techniques and in Beacon's standards and protocols. Utilization Management is available 24/7, 365 days a year to take calls from members and providers. All Beacon employees with responsibility for making UM decisions have been made aware that:

- all utilization review decisions are based on medical necessity
- treatment is specific to the member's condition, is effective and is provided in the least restrictive, most clinically appropriate level of care
- financial incentives based on an individual Utilization Management clinician's number of adverse determinations/adverse actions or denials of payment are prohibited; and
- Utilization Management decision-makers do not receive financial incentives for decisions that result in underutilization.

Note that the information in this chapter, including definitions, procedures, determinations, and notifications may vary for different lines of business. Such differences are indicated where applicable.

8.3. Medical Necessity Level-of-Care (LOC) Criteria

Medical Necessity Criteria varies according to state and/or contractual requirements and member benefit coverage. To determine the proper Medical Necessity Criteria, use the following as a guide:

1. For all Medicare members, first identify relevant Centers for Medicare and Medicaid (CMS) National Coverage Determinations (NCD) or Local Coverage Determinations (LCD) Criteria.

2.If no CMS criteria exists for Medicare members and for all non-Medicare members, identify relevant custom Medical Necessity Criteria.

3.If no custom criteria exists for the applicable level of care and the treatment is substance use related, the American Society of Addiction Medicine (ASAM) criteria would be appropriate.

**Exception: Substance Use Lab Testing Criteria is in InterQual® Behavioral Health Criteria.*

4.If the level of care is not substance use related, Change Healthcare's Interqual® Behavioral HealthCriteria or Milliman Care Guidelines (MCG) would be appropriate and as directed by Health Plan.

5.If 1-4 above are not met, Beacon's National Medical Necessity Criteria would be appropriate.

Beacon has six (6) types of MNC, depending on client or state contractual requirements and lines of business:

A. Centers for Medicare and Medicaid (CMS) Criteria – National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) contained in the Medicare Coverage Database(https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).

B. Milliman Care Guidelines (MCG) Behavioral Health Criteria

C. Change Healthcare's InterQual Behavioral Health Criteria

D. American Society of Addiction Medicine (ASAM) Criteria

E. Custom criteria, including state or client specific levels of care

F. Beacon's National Medical Necessity Criteria

Beacon's LOC criteria are available to all providers upon request. Current and potential providers and members can also access Beacon's LOC criteria as follows:

- Online, via eServices at www.beaconhealthoptions.com
- Telephonically – Callers are assisted by Member Services to have LOC criteria sent either electronically or by hard copy.

Unless otherwise mandated by state or contractual requirement, all medical necessity Behavioral health (BH) determinations are based on the application of Beacon's LOC criteria and the Health Plan/Managed Care Organization (HP/MCO) benefit plan. Beacon's process for conducting utilization review typically is based on chart review and/or direct communications from the evaluating/requesting provider (designee). Beacon will not set or impose any notice or other review procedures contrary to the requirements of the health insurance policy or health benefit plan. Behavioral health authorization and UM activities comply with federal mental health parity law.

To ensure that members receive the care that best meets their individual behavioral health needs in the most appropriate treatment setting, members' needs are assessed and matched with the capabilities, locations and competencies of the provider network when authorizing services. All decisions regarding authorization are made as expeditiously as the case requires, but no longer than required timeliness standards.

A member, authorized representative or treating health care provider may request an expedited authorization decision. If the request is made by a treating health care provider, the request will be granted unless the request is unrelated to the member's health condition. All other requests will be reviewed and decided upon by a Beacon physician advisor.

Beacon does not require a primary care physician (PCP) referral to obtain authorization for behavioral health (BH) services. A member may initiate outpatient behavioral health (BH) services for a predetermined number of visits, without prior authorization from Beacon, as determined by his/her HP/MCO benefit package. Authorization is required for ongoing outpatient services after members exceed the predetermined number of visits allowed by their health plan.

Beacon will cover emergency services for all members whether the emergency services are provided by an affiliated or non-affiliated provider. Beacon does not impose any requirements for prior approval of emergency services.

Unless otherwise specified, all admissions to inpatient mental health and substance use disorder facilities and any diversionary services require prior authorization. Inpatient providers (including Crisis Stabilization Units) are required to notify Beacon of emergent and urgent admissions (Emergency Behavioral Health Care) no later than the next business day following the admission. The number of initial days authorized is dependent on level of care and continued stay is approved or denied based on the findings during concurrent reviews. The decision to provide treatment or service to a member is the responsibility of the attending provider and the member (his or her patient). If the requesting provider does not provide the necessary information for Beacon to make a medical necessity determination, Beacon will make a determination based on the information received within the specified time frames, which may result in an adverse determination/action.

Adverse determinations (denials) are never decided on the basis of pre-review or initial screening and are always made by a Beacon physician/psychologist advisor (PA). All adverse determinations are rendered by board-certified psychiatrists or a psychologist of the same or similar specialty as the services being denied. All Beacon physician/psychologist advisor (PAs) hold current and valid, unrestricted licenses. Treating providers may request reconsideration of an adverse determination from a clinical peer reviewer, which will be completed within one business day of the request. Unless excluded by state regulation, psychologist advisors may deny outpatient services, including psychological testing, except when the requesting provider is a physician or a nurse prescriber; in those cases, a physician advisor must review and make a determination.

Court-ordered treatment benefits vary by state. Please contact Beacon's Member Services department if you have any questions regarding court-ordered treatment and adverse determination rules. Please refer to the health plan-specific Contact Information sheet for the Member Services phone number. Medical necessity determinations are not affected by whether a member is mandated involuntarily to treatment or is voluntarily requesting services. Unless an HP/MCO contract specifies payment for court-ordered treatment, authorization requests for members who are mandated involuntarily to services must meet LOC criteria to be authorized for the treatment. The requested service must also be covered by the member's benefit plan.

Beacon physician/psychologist advisor (PA) are available at any time during the utilization management process, to discuss by telephone, adverse determinations based on medical necessity with attending physicians and other licensed practitioners. Additionally, the treating practitioner may speak with a Beacon physician/psychologist advisor (PA) at any time to discuss any LOC questions the practitioner might have.

In the event the case is outside the physician/psychologist advisor (PA) scope of practice, she/he may consult with, or refer the case to, a practitioner who has experience in treating the condition.

Beacon offers and provides a mechanism for direct communication between a Beacon PA and an attending provider (or provider designated by attending physician) concerning medical necessity determinations. Such equivalent two-way (peer-to-peer) direct communication shall include a telephone conversation and/or facsimile or electronic transmission, if mutually agreed upon. If the attending provider is not reasonably available or does not want to participate in a peer-to-peer review, an adverse determination can be made based on the information available.

Beacon does not terminate, suspend or reduce previously authorized services. Beacon will not retrospectively deny coverage for behavioral health services when prior approval has been issued, unless such approval was based upon inaccurate information material to the review, or the healthcare services were not consistent with the provider's submitted plan of care and/or any restrictions included in the prior approval.

Beacon does not routinely request copies of medical records related to behavioral health treatment requests that are in prospective or concurrent review. Additional medical records will only be requested when there is difficulty in making a decision. Written authorization for release of health information is not required for routine healthcare delivery options. To avoid duplicative requests for information from members or providers, the original requestor of information will ensure all appropriate clinical and administrative staff receives the necessary clinical and demographic information. Practitioners/providers are required by the 2002 Standards for Privacy of Individually Identifiable Health Information (the Privacy Rule), to make a good-faith effort to obtain a patient's written acknowledgement of receipt of privacy rights and practices. Written consent for release of health information is not required for routine healthcare delivery options. When a provider is acting on behalf of a member, written consent from a member to release his/her record is preferred.

Beacon does not routinely require hospitals, physicians or other providers to numerically code diagnoses to be considered for authorization.

For those contracts in which the HP/MCO does not delegate quality management, network management, benefit administration, or triage and referral services, Beacon refers all quality, provider, benefit, network concerns, and other administrative issues directly to the HP/MCO for review and resolution.

In those instances when there is not a state or federal appeal regulation, NCQA standard requirements have been adopted. In all cases, the most stringent standard has been adopted to ensure compliance.

8.4. Utilization Management Terms and Definitions

UTILIZATION MANAGEMENT

Utilization Management includes review of pre-service, concurrent and post-service requests for authorization of services. Beacon Utilization Review Clinicians gather necessary clinical information (from a reliable clinical source) to assist in the certification process and then uses Beacon's LOC criteria to authorize the most appropriate, medically necessary, treatment for the member. Beacon uses its LOC criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths, treatment history in determining the best placement for a member. Authorizations are based on the clinical information gathered at the time of the review.

All concurrent reviews are based on the severity and complexity of the member's condition. A clinical evaluation for medical necessity is conducted at each concurrent review to determine when the next review will be due. For those reviews that do not appear to meet Beacon's LOC criteria a referral is made to a Beacon physician/psychologist advisor (PA). Only a Beacon physician/psychologist advisor (PA) can make an adverse determination/action (denial) decision.

Utilization Management also includes reviewing utilization data resulting from medical necessity decisions. This data is compared to national, local and organizational benchmarks (e.g., average length of stay and readmissions rates) to identify trends. Based on the analysis of the utilization data, specific interventions may be created to increase standardization and decrease fluctuations.

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

Adverse Action/Determination

The following actions or inactions by the organization:

1. Failure to provide covered services in a timely manner in accordance with the waiting time standards;
2. Denial or limited authorization of a requested service, including the determination that a requested service is not a covered service;
3. Reduction, suspension, or termination of a previous authorization for a service;
4. Denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute adverse actions, including but not limited to, denials based on the following:
    a. failure to follow prior authorization procedures
    b. failure to follow referral rules
    c. failure to file a timely claim
5. Failure to act within the time frames for making authorization decisions; and
6. Failure to act within the time frames for making appeal decisions.

Emergency Services

Inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title, and are needed to evaluate or stabilize an emergency medical condition~42CFR438.114(a).

Member

An eligible person who is enrolled in a health plan/managed care organization or a qualifying dependent. The terms “Member” and “Enrollee” are equivalent.

Non-urgent (standard) concurrent review decisions

If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the organization does not meet the definition of urgent care, Beacon will respond to the request within the time frame of a non-urgent, pre-service decision as defined below.

Non-urgent (standard) pre-service decisions

Any case or service that must be approved in advance of a member obtaining care or services. A non-urgent pre-service decision would include treatment over a period of time or a number of days or treatments in a non-acute treatment setting. Requests for continued treatment (concurrent) that are non-urgent are considered, for the purposes of this policy, as new pre-service requests.

Peer review conversation

A peer review conversation is a two-way direct communication between the treating provider and a peer advisor with the same licensure status, offered by Beacon when the initial clinical review does not demonstrate that the requested service is medically necessary. It may also be requested at any time by the treating provider, and it may occur prior to an adverse determination or after, upon request for a reconsideration.

Post-service review and decisions

Any review for care or services that have already been received. A post-service decision would authorize, modify or deny payment for a completed course of treatment where a pre-service decision was not rendered, based on the information that would have been available at the time of a pre service review and treatment stay, also known as retrospective decisions.

Urgent care requests

Any request for medical care or treatment concerning application of the time periods for making non-urgent care decisions:

- could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function, based on a prudent layperson’s judgment; or
- in the opinion of a practitioner with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is requested.

Urgent (expedited) concurrent review decisions

Any reviews for an extension of a previously approved ongoing course of treatment over a period of time or a number of days or treatment in an acute treatment setting or for members whose condition meets the definition of urgent care.

Urgent (expedited) pre-service decisions

Any case or service that must be approved in advance of a member obtaining care or services or for members whose condition meets the definition of urgent care. An urgent pre-service decision would include treatment over a period of time or a number of days or treatments in an acute treatment setting, also known as pre-certification or prospective decision.

UM REVIEW REQUIREMENTS – INPATIENT AND DIVERSIONARY

Pre-Service Review	Continued Stay (Concurrent) Review	Post-Service Review
The facility clinician making the request needs the following information for a pre-service review: • Member's health plan identification number • Member's name, gender, date of birth, and city or town of residence • Admitting facility name and date of admission • ICD or DSM diagnosis: (A provisional diagnosis is acceptable.) • Description of precipitating event and current symptoms requiring inpatient psychiatric care • Medication history • Substance use disorder history • Prior hospitalizations and psychiatric treatment • Member's and family's general medical and social history • Recommended treatment plan relating to admitting symptoms and the member's anticipated response to treatment • Recommended discharge plan following end of requested service	**To conduct a continued stay review, call** **a Beacon UR clinician with the following required information:** • Member's current diagnosis and treatment plan, including physician's orders, special procedures, and medications • Description of the member's response to treatment since the last concurrent review • Member's current mental status, discharge plan, and discharge criteria, including actions taken to implement the discharge plan • Report of any medical care beyond routine is required for coordination of benefits with health plan (routine medical care is included in the per diem rate).	Post-service reviews may be conducted for inpatient, diversionary or outpatient services rendered when necessary. To initiate a post-service review, please submit your request via mail: Beacon Health Options P.O. Box 1870 Hicksville, NY 11802-1870 If the treatment rendered meets criteria for a post-service review, the UR clinician will request clinical information from the provider, including documentation of presenting symptoms and treatment plan via the member's medical record. Beacon requires only those section(s) of the medical record needed to evaluate medical necessity and appropriateness of the admission, extension of stay, and the frequency or duration of service. A Beacon physician or psychologist advisor completes a clinical review of all available

		information, in order to render a decision. If an authorization was not requested prior to services being rendered, provider should submit a cover letter providing justification as to why the authorization was not obtained along with any supporting documentation.

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

Return of Inadequate or Incomplete Treatment Requests

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

Notice of Inpatient/Diversionary Approval or Denial

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

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

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

Outpatient Initial Encounters (IEs)

Some plans allowed a fixed number of initial therapy sessions without prior authorization (will vary by plan and member benefit; please refer to member's plan benefit). Providers may search the number of IEs billed to Beacon via eServices. Please be aware the member may have used additional visits that have not been billed or through another provider that are not viewable in eServices. If a member has exhausted his/her IEs (or is close to the limit), the new provider must obtain authorization before beginning treatment. Please see plan benefits to determine what services count against the member's IEs.

Termination of Outpatient Care

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

8.5. Decision and Notification Time Frames

Beacon is required by states, federal government, NCQA and URAC to render utilization review decisions in a timely manner to accommodate the clinical urgency of a situation. The maximum time frames on a case-by-case basis in accordance with state, federal government, NCQA or URAC requirements that have been established for each line of business. In all cases, Beacon has adopted the strictest time frame for all UM decisions in order to comply with the various requirements. All time frames begin at the time of Beacon's receipt of a request.

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

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

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

- First Level administrative appeals for plan members should be submitted in writing to the appeals coordinator at Beacon. Provide any supporting documents that may be useful in making a decision (Do not submit medical records or any clinical information). An administrative appeals committee reviews the appeal, and a decision is made within 20 business days of the date of receipt of the appeal. A written notification is sent within three business days of the appeal determination.
- Second Level administrative appeals for plan members should be submitted in writing to the Director of Appeals at Beacon. A decision is made within 20 business days of receipt of appeal information, and notification of the decision is sent within three business days of appeal determination.
- Appeals may be mailed to:

Beacon Health Options

P.O. Box 1872

Hicksville, NY 11802-1872

Chapter 9

Telemedicine

9.1. Telemedicine

As a part of its Quality Enhancement programs, and in accordance with the requirements specified in Attachment II, Section VI.F., Quality Enhancements, Beacon will ensure that members have a choice of whether they would like to access services through a face-to-face session or telemedicine encounter with a behavioral health provider. In addition, Beacon will cover the following telemedicine modalities: store-and-forward and remote patient monitoring services and will confirm that the member's records include documentation, as applicable, when telemedicine services are provided.

When providing services through telemedicine, Beacon ensures that the telecommunication equipment and telemedicine operations meet the technical safeguards required by 45 CFR 164.312, where applicable and that providers using telemedicine comply with HIPAA laws pertaining to patient privacy. Beacon will provide training to providers regarding the telemedicine requirements.