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SECTION III – BEHAVIORAL HEALTH

1. PROGRAM DESCRIPTION

1.1. Beacon/Humana Partnership

Humana has partnered with Beacon Health Options (Beacon) to manage the delivery of behavioral health services for its Medicaid Medicare Alignment Initiative (MMAI) Demonstration and Integrated Care Plan (ICP) Members in Illinois. The Demonstration is designed to provide Members who are dually eligible for both Medicare and Medicaid with high quality, integrated care. Members enrolled in the Demonstration and ICP programs are eligible to receive comprehensive assessments, care planning and coordination from Humana. For further details, please refer to the Humana section of this Provider Manual Appendix.

Beacon provides behavioral health management services to 50 million people, through partnerships with over 50 Health Plan partners in 50 states. Most often co-located at the physical location of our Health Plan partners, Beacon's "in-sourced" approach deploys utilization managers, care managers and Provider network professionals into each local market where Beacon conducts business. This approach facilitates better coordination of care for Members with physical, behavioral and social conditions and is designed to support a "medical home" model. Quantifiable results prove that this approach improves the lives of individuals and their families and helps Health Plans to better integrate behavioral health with medical health.

1.2. Beacon/Humana Behavioral Health Program

The Humana behavioral health program provides Members with access to a full continuum of behavioral health services through our network of Beacon Network Providers. The primary goal of the program is to provide Medically Necessary care in the most clinically appropriate and cost-effective therapeutic settings. By ensuring that all Health Plan Members receive timely access to clinically appropriate behavioral healthcare services, Humana and Beacon believe that quality clinical services can achieve improved outcomes for our Members.

1.3. Network Operations

Beacon's Network Operations Department, with Provider Relations, is responsible for the procurement and administrative management of Beacon's behavioral health Provider network. Beacon's role includes contracting, credentialing and Provider relations functions for all behavioral health contracts. Representatives are easily reached by email at provider.relations@beaconhealthoptions.com, or by phone between 8:30 a.m. – 6 p.m. Eastern time, Monday – Thursday, and 8:30 a.m. – 5 p.m. Eastern time on Fridays at 1-855-481-7044 for routine matters. Additionally, Beacon clinical staff is available 24 hours a day seven days a week for authorization requests by calling 1-855-481-7044.

1.4. Contracting and Maintaining Network Participation

A Beacon "Network Provider" is an individual practitioner, private group practice, licensed outpatient agency, or facility that has been credentialed by Beacon and has signed a Provider Services Agreement (PSA) with Beacon and Humana. Network Providers agree to provide

behavioral health and/or substance use Covered Services to Members, to accept reimbursement according to the rates as set forth in each Provider's PSA, and to adhere to all other terms in the PSA including this Provider Manual Appendix.

Beacon Network Providers who maintain approved credentialing status remain active Network Providers unless the PSA is terminated in accordance with the terms and conditions set forth therein. In cases where a Network Provider is terminated, such Providers may notify the Member of their termination. Beacon will also always notify Members when their Provider has been terminated and work to transition Members to another Network Provider to avoid unnecessary disruption of care.

1.5. About This Provider Manual Appendix

This Behavioral Health Provider Policy and Procedure Manual Appendix (referred to herein as the "Appendix" or the "Manual") is a legal document incorporated by reference as part of each Provider's Beacon Provider Services Agreement or Humana Provider Participation Agreement.

The Manual serves as an administrative guide outlining Beacon's policies and procedures governing network participation, service provision, claims submission, quality management and improvement requirements, in Chapters 1–3. Detailed information regarding clinical processes, including authorizations, utilization review, care management, reconsiderations and Provider Appeals are found in Chapters 4 and 5. Chapter 6 covers billing transactions. Beacon's level of care criteria (LOCC) are accessible through eServices or by calling Beacon at 1-855-481-7044.

Additional information is can be found on the Beacon website at www.beaconhealthoptions.com. The Manual is posted on both Humana and Beacon's websites and on Beacon's eServices; only the version on eServices includes Beacon's LOCC. Providers may also request a printed copy of the Manual by calling 1-855-481-7044.

Updates to the Manual as permitted by the Provider Services Agreement will be posted on the Humana and Beacon websites, and notification may also be sent by postal mail and/or electronic mail. Beacon provides notification to Network Providers at least 60 days prior to the effective date of any policy or procedural change that impacts Network Providers, such as modification in payment or covered services. Beacon provides 60 days' notice unless the change is mandated sooner by State or Federal requirements.

1.6. Transactions and Communications with Beacon

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

Electronic Media

To streamline Network Providers' business interactions with Beacon, we offer three Provider tools:

a) eServices

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 Beacon Network Providers contracted for Humana and is accessible through www.beaconhealthoptions.com 24 hours a day, seven days a week. 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.

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

b) Interactive Voice Recognition

Interactive voice recognition (IVR) is available to Providers as an alternative to eServices. It provides accurate, up-to-date information by telephone, and is available for selected transactions at 1-888-210-2018.

In order to maintain compliance with HIPAA and all other Federal and State confidentiality/privacy requirements, Network Providers must have their practice or organizational Tax Identification Number (TIN), National Provider Identifier (NPI), as well as Member's full name, Plan ID and date of birth, when verifying eligibility through eServices and through Beacon's IVR.

c) Electronic Data Interchange

Electronic data interchange (EDI) is available for claim submission and eligibility verification directly by Providers to Beacon or via an intermediary. For information about testing and setup for EDI, download Beacon's 837 and 835 companion guides.

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Beacon accepts standard HIPAA 837 professional and institutional healthcare claim transactions and provides 835 remittance advice response transactions.

To set up an EDI connection, view the companion guide located on Beacon's Provider Portal at www.beaconhealthoptions.com, then contact edi.operations@beaconhealthoptions.com.

You may submit any technical and business-related questions to the same address. To submit EDI claims through an intermediary, contact the intermediary for assistance. If using Emdeon, use Beacon's Emdeon Payer ID 43324 and Beacon's Health Plan 054.

TABLE 1-1: ELECTRONIC TRANSACTIONS AVAILABILITY

Transaction/ Capability	eServices	IVR	EDI
Verify member eligibility, benefits, and copayments	Yes	Yes	
Check number of visits available	Yes	Yes	
Submit authorization requests	Yes		
View authorization requests	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	
Print claims reports and graphs	Yes		
Download electronic remittance advice	Yes		
EDI acknowledgement and submission reports	Yes		Yes (HIPAA 835)

TABLE 1-1: ELECTRONIC TRANSACTIONS AVAILABILITY			
Transaction/ Capability	**eServices**	**IVR**	**EDI**
Pend authorization requests for internal approval	Yes		
Access Beacon's level of care criteria and Provider Manual	Yes		

Email
Beacon encourages Providers to communicate with Beacon by email addressed to provider.relations@beaconhealthoptions.com.

Throughout the year Beacon sends Network 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.

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

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

1.7. Access Standards

Humana Members may access behavioral health services 24 hours a day, seven days a week by contacting Humana's Member services line 1-855-481-7044. The main Humana line includes an option for connecting directly to Beacon Health Options Member services for emergencies or authorization requests for acute levels of care. For most Members, referrals are not required to access behavioral health services. Authorization and referrals are never required for emergency services.

Humana and Beacon adhere to State and National Committee for Quality Assurance (NCQA) guidelines for access standards for Member appointments. Network Providers must adhere to the following:

TABLE 1-2: APPOINTMENT STANDARDS AND AFTER-HOURS ACCESSIBILITY	
Type of Care	**Appointment Availability**
Emergency care with crisis stabilization	Within 24 hours

TABLE 1-2: APPOINTMENT STANDARDS AND AFTER-HOURS ACCESSIBILITY	
Type of Care	**Appointment Availability**
Urgent care	Within 48 hours
Post-discharge from acute hospitalization	Within seven days of discharge
Other routine referrals/appointments	Within 60 days

Access standards for Humana's behavioral health network are established to ensure that Members have access to services within thirty (30) miles or a maximum of thirty (30) minutes of their address in urban areas, and sixty (60) miles or a maximum of sixty (60) minutes of their address in rural areas.

In addition, Humana Providers must adhere to the following guidelines to ensure Members have adequate access to services:

TABLE 1-2: APPOINTMENT STANDARDS AND AFTER-HOURS ACCESSIBILITY	
Service Availability	**Hours of Operation**
On-call	• 24-hour on-call services for all Members in treatment • Ensure that all Members in treatment are aware of how to contact the treating or covering Provider after hours and during Provider vacations.
Crisis intervention	• Services must be available 24 hours per day, seven days per week • Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours • After hours, Providers should have a live telephone answering service or an answering machine that specifically directs a Member in crisis to a covering physician, agency-affiliated staff, crisis team, or hospital emergency room.
Outpatient Services	• Outpatient Providers should have services available Monday – Friday from 9 a.m. – 5 p.m. at a minimum • Evening and/or weekend hours also should be available at least two days per week.

TABLE 1-2: APPOINTMENT STANDARDS AND AFTER-HOURS ACCESSIBILITY	
Service Availability	**Hours of Operation**
Interpreter Services	• Under State and Federal law, Providers are required to provide interpreter services to communicate with individuals with limited English proficiency.
Cultural Competency	• Providers must ensure that Members have access to medical interpreters, signers and TTY services to facilitate communication when necessary and ensure that clinicians and agencies are sensitive to the diverse needs of Humana Members.

Medical Homes
All Providers are encouraged to consider an affiliation with a Medical Home. Some Providers may serve as a Medical Home, which is designed to provide fully integrated care for Members. For further information on the Medical Home model, please contact us at 1-855-481-7044.

Members with Disabilities
Provider locations shall be accessible for Humana Members with disabilities. As necessary to serve Members, Provider locations where Members receive services shall be compliant with the Adults with Disabilities Act (ADA). Providers may be required to attest that their facilities are ADA compliant.

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

1.8. Provider Credentialing and Recredentialing

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

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

Provider Training
Please see subsection 8 of Section III of this Appendix, below.

1.9. Prohibition on Billing Members

Health Plan Members may not be billed for any covered service or any balance after reimbursement by Beacon except for any applicable copayment. Further, Providers may not charge Demonstration or ICP Members for any services that are not deemed Medically Necessary upon clinical review or which are administratively denied. It is the Provider's responsibility to check benefits prior to beginning treatment for any Demonstration or ICP Member and to follow the procedures set forth in this Manual.

Out-of-Network Providers

Out-of-network behavioral health benefits are limited to those covered services that are not available in the existing Humana/Beacon network, emergency services and transition services for Members who are currently in treatment with an out-of-network Provider who either is not a part of the network or who is in the process of joining the network, or otherwise required by Humana's contract with the State. Out-of-network Providers must complete a single case agreement (SCA) with Beacon. Out-of-network Providers may provide one evaluation visit for Humana Members without an authorization upon completion and return of the signed SCA. After the expiration of existing authorizations, services provided must be authorized by Beacon. Authorization requests for outpatient services can be obtained by calling 1-855-481-7044. If this process is not followed, Beacon may administratively deny the services and the out-of-network Provider must hold the Member harmless.

Out-of-network Providers who wish to join Beacon's network should contact our network department by calling 1-855-481-7044.

Provider Database

Beacon and Humana maintain a database of Provider information as reported to us by Providers. This database can be found on Beacon's website at www.beaconhealthoptions.com. A hard copy can be requested through 1-855-481-7044. The accuracy of this database is critical to operations, for such essential functions as:

- Member referrals
- Regulatory reporting requirements
- 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 us to use 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. The table below lists required notifications. Most of these can be updated via Beacon's eServices portal or by email.

TABLE 1-3: REQUIRED NOTIFICATIONS
Type of Information
General Practice Information
• Change in address or telephone number of any service
• Addition or departure of any professional staff
• Change in linguistic capability, specialty, or program
• Discontinuation of any covered service listed in the Behavioral Health Services Agreement
• Change in licensure or accreditation of provider or any of its professional staff
• Change in hours of operation
• Is no longer accepting new members
• Is available during limited hours or only in certain settings
• Has any other restrictions on treating members
• Is temporarily or permanently unable to meet Beacon standards for appointment access
• Change in designated account administrator for the Provider's eServices accounts
• Merger, change in ownership, or change in tax identification number
• Where adding a site, service, or program not previously included in the Behavioral Health Services Agreement, remember to specify: a. Location b. Capabilities of the new site, service, or program

Adding Sites, Services, and Programs
Your contract with Beacon is specific to the sites, rates and services for which you originally specified in your PSA.

To add a site, service or program not previously included in your PSA, you should notify Beacon of the location and capabilities of the new site, service or program. Beacon will coordinate with Humana to determine whether the site, service or program meets an identified geographic, cultural/linguistic, and/or specialty need in our network.

2. MEMBERS, BENEFITS, AND MEMBER-RELATED POLICIES

2.1. Covered Services

Humana covers behavioral health and substance use services via Beacon which are provided to Members located in the Greater Chicago service area, including the counties of Cook, Du Page, Kane, Kankakee, Lake and Will. Under the Health Plan, the following levels of care are covered, provided that such services are Medically Necessary, delivered by contracted Network Providers (or as part of a Member's transition plan if Provider is not in network), and that the authorization procedures outlined in this Manual are followed. Please refer to your contract with Beacon for specific information about procedure and revenue codes and rates for each service.

- Outpatient Behavioral Health and Substance Use Services
- Community-based (Rule 132) Mental Health Services
- Partial Hospitalization
- Intensive Outpatient Services
- Division on Alcohol and Substance Use Services
- Inpatient Hospitalization
- Crisis Stabilization and Observation
- ER Services

Access to behavioral health treatment is an essential component of a comprehensive health care delivery system. Plan Members may access behavioral health services by self-referring to a network Provider, by calling Beacon, or by referral through acute or emergency room encounters. Members may also access behavioral health services by referral from their primary care practitioner (PCP). Some behavioral health and substance use services for Demonstration and/or ICP Members may require referral from the Member's PCP. Please contact Beacon for more information about referral requirements. Network Providers are expected to coordinate care with a Member's PCP and other treating Providers whenever possible.

Additional Benefit Information

- Benefits do not include payment for behavioral healthcare services that are not Medically Necessary.
- Neither Beacon nor the 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 Medically Necessary for the Member's care.
- Authorization may be required for all services.
- Opioid Maintenance is not a covered benefit except emergency services.
- Detailed information about authorization procedures is covered in Chapter 4 of this Manual.

2.2. Member Rights and Responsibilities

MEMBER RIGHTS

Humana and Beacon are firmly committed to ensuring that Members are active and informed participants in the planning and treatment phases of their behavioral care. We believe that Members become empowered through ongoing collaboration with their healthcare Providers,

and that collaboration among Providers is also crucial to achieving positive healthcare outcomes.

Members must be fully informed of their rights to access treatment and to participate in all aspects of treatment planning. Members may request assistance from Beacon or Humana in filing an Appeal or a State hearing once their Appeal rights have been exhausted. Member rights and responsibilities, generally, are outlined above in Section I of this Appendix.

Right to Submit a Complaint or Concern to Beacon
Members and their legal guardians have the right to file a Complaint or Grievance with Beacon or the Plan regarding any of the following. Member Grievances will be handled directly by Humana.

- The quality of care delivered to the Member by a Beacon network Provider
- The Beacon utilization review process
- The Beacon network of services
- The procedure for filing a Complaint or Grievance as described in Chapter 3

Right to Contact Beacon Ombudsperson
Members have the right to contact Beacon's Office of Ombudsperson to obtain a copy of Beacon's Member Rights and Responsibilities statement. The Beacon Ombudsperson may be contacted at 1-855-481-7044 or by TTY at 1-855-539-5884.

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

Posting Member Rights and Responsibilities
All Network Providers must display, in a highly visible and prominent place, a statement of Member's Rights and Responsibilities. This statement must be posted and made available in languages consistent with the demographics of the population(s) served. This statement can either be Beacon's statement or a comparable statement consistent with the Provider's State license requirements.

Informing Members of Their Rights and Responsibilities
Providers are responsible for informing Members of their rights and respecting these rights. In addition to a posted statement of Member rights, Providers are also required to:

- Distribute and review a written copy of Member Rights and Responsibilities at the initiation of every new treatment episode and include in the Member's medical record signed documentation of this review
- Inform Members that Beacon does not restrict the ability of Network Providers to communicate openly with Plan Members regarding all treatment options available to them including medication treatment regardless of benefit coverage limitations

- Inform Members that Beacon does not offer any financial incentives to its Network Provider community for limiting, denying, or not delivering Medically Necessary treatment to Plan Members
- Inform Members that clinicians working at Beacon do not receive any financial incentives to limit or deny any Medically Necessary care

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

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

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

It is our joint goal to ensure that all Members receive Medically Necessary behavioral health care that is accessible, respectful, and maintains the dignity of the Member.

Confidentiality of Member Information
All Providers are expected to comply with Federal, State and local laws regarding access to Member information. With the enactment of the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Members give consent for the release of information regarding treatment, payment and healthcare operations at the signup for health insurance. Treatment, payment and healthcare operations involve a number of different activities, including, but not limited to:

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

Member Consent
At every intake and admission to treatment, Providers should explain the purpose and benefits of communication to the Member's PCP and other relevant Providers. The behavioral health clinician should then ask the Member to sign a statement authorizing the clinician to share clinical status information with the PCP and for the PCP to respond with additional Member status information. A sample form is available at www.beaconhealthoptions.com or Providers may use their own form; the form must allow the Member to limit the scope of information communicated.

Members can elect to authorize or refuse to authorize release of any information, except as specified in the previous section, for treatment, payment and operations. Whether consenting or declining, the Member's signature is required and should be included in the medical record. If a Member refuses to release information, the Providers should clearly document the Member's reason for refusal in the narrative section on the form. In addition, the Provider should advise the Member that if they refuse authorization to release information for payment purposes, they will be held personally responsible for payment outside their Health Plan.

Confidentiality of Members' HIV-related Information
At every intake and admission to treatment, Providers should explain the purpose and benefits of Beacon works in collaboration with the Plan to provide comprehensive health services to Members with health conditions that are serious, complex, and involve both medical and behavioral health factors. Beacon coordinates care with Health Plan medical and disease management programs and accepts referrals for behavioral healthcare management from the Health Plan. Information regarding HIV infection, treatment protocols and standards, qualifications of HIV/AIDS treatment specialists, and HIV/AIDS services and resources, medications, counseling and testing is available directly from Health Plan. Beacon will assist behavioral health Providers or Members interested in obtaining any of this information by referring them to the Health Plan's care management department. Beacon limits access to all health-related information, including HIV-related information and medical records, to staff trained in confidentiality and the proper management of patient information. Beacon's care management protocols require Beacon to provide any Health Plan Member with assessment and referral to an appropriate treatment source. It is Beacon's policy to follow Federal and State information laws and guidelines concerning the confidentiality of HIV-related information.

Humana Health Plan Member Eligibility
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. The following resources are available to assist in eligibility verification:

TABLE 2-1: MEMBER ELIGIBILITY VERIFICATION TOOLS	
Online	**Via Telephone**
Beacon's eServices	1-888-210-2018 Beacon's Interactive Voice Recognition (IVR)

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Providers may also use the Humana secure Provider Portal online to check Member eligibility, or call Provider Services.

Provider Services:
Provider Portal
Click on "Member Eligibility" on the left, which is the first tab.

- Go to www.beaconhealthoptions.com and select Providers from the menu options.
- Using our secure Provider Portal, you can check Humana Member eligibility up to 24 months after the date of service. You can search by date of service plus any one of the following: Member name and date of birth, case number, Medicaid (MMIS) number, or Humana Member ID number. You can submit multiple Member ID numbers in a single request.
- Call our automated Member eligibility verification system at 1-855-481-7044 from any touchtone phone and follow the appropriate menu options to reach our automated Member eligibility verification system. The automated system, available 24 hours a day, will prompt you to enter the Member ID number and the month of service to check eligibility.

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

The Beacon Clinical Department may also assist the Provider in verifying the Member's enrollment in the Humana Health Plan when authorizing services. Due to implementation of the Privacy Act, Beacon requires the Provider to have ready specific identifying information (Provider ID number, Member's 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.

3. QUALITY MANAGEMENT AND IMPROVEMENT

3.1. QM&I Program Overview

TABLE 3-1: PROGRAM OVERVIEW		
Program Description	**Program Principles**	**Program Goals and Objectives**
Beacon administers, on behalf of the Health Plan, a Quality Management and Improvement (QM&I)	• Continually evaluate the effectiveness of services delivered to Health Plan Members	• Improve the healthcare status of Members • Enhance continuity and coordination among behavioral

TABLE 3-1: PROGRAM OVERVIEW		
Program Description	**Program Principles**	**Program Goals and Objectives**
program whose goal is to continually monitor and improve the quality and effectiveness of behavioral health services delivered to Members. Beacon's QM&I Program integrates the principles of continuous quality improvement (CQI) throughout our organization and the Provider network.	• Identify areas for targeted improvements • Develop QI action plans to address improvement needs • Continually monitor the effectiveness of changes implemented, over time	healthcare Providers and between behavioral healthcare and physical healthcare Providers • Establish effective and cost efficient disease management programs, including preventive and screening programs, to decrease incidence and prevalence of behavioral health disorders • Ensure Members receive timely and satisfactory service from Beacon and network Providers • Maintain positive and collaborative working relationships with network practitioners and ensure Provider satisfaction with Beacon services • Responsibly contain healthcare costs

Provider Role
Humana and Beacon employ a collaborative model of continuous QM&I, in which Provider and Member participation is actively sought and encouraged. Humana and Beacon require each Provider to have its own internal QM & I Program to continually assess quality of care, access to care and compliance with Medical Necessity criteria.

All Providers are expected to provide Members with disease-specific information and preventive care information that can assist the Member in understanding his/her illness and help support their recovery. Member education should be person-centered, recovery-focused and promote compliance with treatment directives and encourage self-directed care.

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

Quality Monitoring
Beacon monitors Provider activity and utilizes the data generated to assess Provider performance related to quality initiatives and specific core performance indicators. Findings related to Provider compliance with performance standards and measures are also used in credentialing and recredentialing activities, benchmarking, and to identify individual Provider

and network-wide improvement initiatives. Humana and Beacon's quality monitoring activities include, but are not limited to:

- Site visits
- Treatment record reviews
- Satisfaction surveys
- Internal monitoring of timeliness and accuracy of claims payment, Provider compliance with performance standards including, but not limited to:
    - Timeliness of ambulatory follow-up after behavioral health hospitalization
    - Discharge Planning Activities
    - Communication with Member PCPs, other behavioral health Providers, government and community agencies
    - Tracking of adverse incidents, Complaints, Grievances and appeals
    - Other quality improvement activities

On a quarterly basis, Beacon's QM&I Department aggregates and trends all data collected and presents the results to the QI Committee for review. The QI Committee may recommend initiatives at individual Provider sites and throughout Beacon's behavioral health network as indicated.

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

3.2. Treatment Records

Treatment Record Reviews

Beacon reviews Member charts and utilizes data generated to monitor and measure Provider performance in relation to Beacon's Treatment Record Standards and specific quality initiatives established each year: The following elements are evaluated in addition to any Illinois State specific regulatory requirements around chart review for special services such as Rule 132 services.

- Use of screening tools for diagnostic assessment of substance use, adolescent depression and ADHD
- Continuity and coordination with primary care Providers and other treaters
- Explanation of Member Rights and Responsibilities
- Inclusion of all applicable required medical record elements as required by the State as identified in administrative regulations and service manuals, and NCQA
- Allergies and adverse reactions, medications, physical exam and evidence of advance directives

Humana and Beacon may conduct chart reviews on-site at a Provider facility, or may ask a Provider to copy and send specified sections of a Member's medical record to Beacon. Any questions that a Provider may have regarding Beacon's access to the Plan Member information should be directed to Beacon's privacy officer at compliance@beaconhealthoptions.com. HIPAA regulations permit Providers to disclose information without patient authorization for the

following reasons: oversight of the healthcare system, including quality assurance activities. Beacon chart reviews fall within this area of allowable disclosure.

Treatment Record Standards
To ensure that the appropriate clinical information is maintained within the Member's treatment record, Providers must follow the documentation requirements below. All documentation must be clear and legible. Providers should also adhere to State guidelines around treatment records, such as Rule 132 documentation guidelines, where indicated.

TABLE 3-2: TREATMENT DOCUMENTATION STANDARDS	
Member Identification Information	The treatment record contains the following member information: ▪ Member name and Plan ID # on every page ▪ Member's address ▪ Employer or school ▪ Home and work telephone # ▪ Marital/legal status ▪ Appropriate consent forms ▪ Guardianship information, if applicable
Informed Member Consent for Treatment	The treatment record contains signed consents for the following: ▪ Implementation of the proposed treatment plan ▪ Any prescribed medications ▪ Consent forms related to interagency communications ▪ Individual consent forms for release of information to the member's PCP and other behavioral health providers, if applicable; each release of information to a new party (other than Beacon or the plan) requires its own signed consent form ▪ Consent to release information to the payer or MCO (In doing so, the provider is communicating to the member that treatment progress and attendance will be shared with the payer.) ▪ For adolescents, ages 12–17, the treatment record contains consent to discuss behavioral health issues with their parents

TABLE 3-2: TREATMENT DOCUMENTATION STANDARDS	
	▪ Signed document indicating review of patient's rights and responsibilities
Medication Information	Treatment records contain medication logs clearly documenting the following: ▪ All medications prescribed ▪ Dosage of each medication ▪ Dates of initial prescriptions ▪ Information regarding allergies and adverse reactions ▪ Lack of known allergies and sensitivities to substances
Medical and Psychiatric History	Treatment record contains the member's medical and psychiatric history including: ▪ Previous dates of treatment ▪ Names of providers ▪ Therapeutic interventions ▪ Effectiveness of previous interventions ▪ Sources of clinical information ▪ Relevant family information ▪ Results of relevant laboratory tests ▪ Previous consultation and evaluation reports
Substance Use Information	Documentation for any member 12 years and older of past and present use of the following: ▪ Cigarettes ▪ Alcohol ▪ Illicit, prescribed, and over-the-counter drugs
Adolescent Depression Information	Documentation for any member 13-18 years who was screened for depression: ▪ If yes, was a suicide assessment conducted? ▪ Was the family involved with treatment?
ADHD Information	Documentation that members aged 6-12 were assessed for ADHD

TABLE 3-2: TREATMENT DOCUMENTATION STANDARDS	
	▪ Was family involved with treatment? ▪ Is there evidence of the member receiving psychopharmacological treatment?
Diagnostic Information	▪ Risk management issues (e.g., imminent risk of harm, suicidal ideation/intent, and elopement potential) are prominently documented and updated according to provider procedures ▪ All relevant medical conditions are clearly documented, and updated as appropriate ▪ Member's presenting problems and the psychological and social conditions that affect their medical and psychiatric status ▪ A complete mental status evaluation is included in the treatment record, which documents the member's: a. Affect b. Speech c. Mood d. Thought control, including memory e. Judgment f. Insight g. Attention/concentration h. Impulse control i. Initial diagnostic evaluation and DSM diagnosis that is consistent with the stated presenting problems, history, mental status evaluation, and/or other relevant assessment information j. Diagnoses updated at least quarterly basis
Treatment Planning	The treatment record contains clear documentation of the following: ▪ Initial and updated treatment plans consistent with the member's diagnoses, goals, and progress ▪ Objective and measurable goals with clearly defined time frames for achieving goals or resolving the identified problems ▪ Treatment interventions used and their consistency with

TABLE 3-2: TREATMENT DOCUMENTATION STANDARDS	
	stated treatment goals and objectives ▪ Member, family, and/or guardian's involvement in treatment planning, treatment plan meetings and discharge planning ▪ Copy of *Outpatient Review Form(s)* submitted, if applicable
Treatment Documentation	The treatment record contains clear documentation of the following: ▪ Ongoing progress notes that document the member's progress towards goals, as well as his/her strengths and limitations in achieving said goals and objectives ▪ Referrals to diversionary levels of care and services if the member requires increased interventions resulting from homicidality, suicidality or the inability to function on a day-to-day basis ▪ Referrals and/or member participation in preventive and self-help services (e.g., stress management, relapse prevention, Alcoholics Anonymous, etc.) is included in the treatment record. ▪ Member's response to medications and somatic therapies
Coordination and Continuity of Care	The treatment record contains clear documentation of the following: ▪ Documentation of communication and coordination between behavioral health providers, primary care physicians, ancillary providers, and health care facilities. (See Behavioral Health – PCP Communication Protocol later in this chapter, and download *Behavioral Health – PCP Communication Form*) ▪ Dates of follow-up appointments, discharge plans, and referrals to new providers

TABLE 3-2: TREATMENT DOCUMENTATION STANDARDS	
Additional Information for Outpatient Treatment Records	These elements are required for the outpatient medical record: ▪ Telephone intake/request for treatment ▪ Face sheet ▪ Termination and/or transfer summary, if applicable ▪ The following clinician information on every entry (e.g., progress notes, treatment notes, treatment plan, and updates) should include the following treating clinician information: a. Clinician's name b. Professional degree c. Licensure d. NPI or Beacon identification number, if applicable e. Clinician signatures with dates
Additional Information for Inpatient and Diversionary Levels of Care	These elements are required for inpatient medical records: ▪ Referral information (ESP evaluation) ▪ Admission history and physical condition ▪ Admission evaluations ▪ Medication records ▪ Consultations ▪ Laboratory and x-ray reports ▪ Discharge summary and *Discharge Review Form*
Information for Children and Adolescents	A complete developmental history must include the following information: ▪ Physical, including immunizations ▪ Psychological ▪ Social ▪ Intellectual ▪ Academic ▪ Prenatal and perinatal events are noted

In addition to the requirements above, for each MMAI Demonstration Member, Providers are also required to capture the following information in the Member's medical record:

- Date of birth
- A summary of significant surgical procedures
- Description of chief complaint or purpose of visit, the objective diagnosis, medical findings, and the impression of the Provider
- Identification of any studies ordered
- Identification of any therapies administered and prescribed
- Disposition, recommendations, instructions to the Member, evidence of whether there was follow-up and outcome of services
- Immunization history
- Summaries of all emergency services and care and hospital discharges with appropriate follow-up
- Documentation of referral services and Member's medical records
- All services provided by Provider (family planning services, preventive services, etc.)
- Primary language spoken by the Member and any translation needs of Member
- Identify Members needing communication assistance in the delivery of healthcare services.

Advance Directives
Beacon practices an integrated approach to advance directives between behavioral health and medical care Providers. As per Federal law (Patient Self-determination Act, 42 U.S.C.A. § 1396a[w] [West 1996]), Providers participating in the Medicare and Medicaid programs are required to furnish patients with information on advance directives. The information is to be given to patients upon admission to a facility or when provision of care begins. Documentation that the Member was provided with this information must be noted in the Member's treatment record. The documentation must also specify whether the Member has executed an Advanced Directive. The Member's Advance Directive decision should be periodically reviewed between the Provider, Member, and/or the Member's legal guardian (if applicable). This should be closely coordinated with the care manager around significant changes in the Member's condition, diagnosis, and/or level of care.

Illinois law allows for the following three types of advance directives: (1) healthcare power of attorney; (2) living will; and (3) mental health treatment preference declaration. Providers should ensure that Members are informed of these rights.

Forms and documentation regarding advanced directives can be downloaded from http://www.idph.state.il.us/public/books/advin.htm.

Performance Standards and Measures
To ensure a consistent level-of-care within the Provider network, and a consistent framework for evaluating the effectiveness of care, Beacon has developed specific Provider performance standards and measures. Behavioral health Providers are expected to adhere to the performance standards for each level of care they provide to Members, which include, but are not limited to:

- Communication with PCPs and other Providers treating shared Members
- Availability of routine, urgent and emergent appointments (See Chapter 4)

Practice Guidelines
Beacon and Humana promote delivery of behavioral health treatment based on scientifically proven methods. We have researched and adopted evidenced-based guidelines for treating the most prevalent behavioral health diagnoses, including guidelines for ADHD, substance use disorders, and child/adolescent depression, and posted links to these on our website. We strongly encourage Providers to use these guidelines and to consider these guidelines whenever they may promote positive outcomes for clients. Beacon monitors Provider utilization of guidelines through the use of claim, pharmacy and utilization data.

Beacon welcomes Provider comments about the relevance and utility of the guidelines adopted by Beacon, any improved client outcomes noted as a result of applying the guidelines, and about Providers' experience with any other guidelines. To provide feedback, or to request paper copies of the practice guidelines adopted by Beacon, contact us.

Outcome Measurement
Beacon strongly encourages and supports Providers in the use of outcome measurement tools for all Members. Outcome data is used to identify potentially high-risk Members who may need intensive behavioral health, medical, and/or social care management interventions. Humana requires that Providers document attempts to communicate with Member primary care Providers, with Member consent. Providers are expected to submit quarterly (monthly if applicable) reports to the Member's PCP on Member treatment and progress.

Beacon receives aggregate data by Provider including demographic information and clinical and functional status without Member-specific clinical information.

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

Communication between Outpatient Behavioral Health Providers and PCPs, Other Treaters	**Communication between Inpatient/ Diversionary Providers and PCPs, Other Treaters**
Outpatient behavioral health Providers are expected to communicate with the Member's PCP and other outpatient behavioral health Providers if applicable, as follows: • Notice of commencement of outpatient treatment within four visits or two weeks, whichever occurs first • Updates at least quarterly during the course of treatment	With the Member's informed consent, acute care facilities should contact the PCP by phone and/or by fax, within 24 hours of a Member's admission to treatment. Inpatient and diversionary Providers also must alert the PCP 24 hours prior to a pending discharge, and must fax or mail the following Member information to the PCP within three days post-discharge: • Date of Discharge • Diagnosis

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

- Notice of initiation and any subsequent modification of psychotropic medications
- Notice of treatment termination within two weeks

Behavioral Health Providers may use Beacon's Authorization for Behavioral Health Provider and PCP to Share Information and the Behavioral Health-PCP Communication Form available for initial communication and subsequent updates, on Beacon's Provider portal at www.beaconhealthoptions.com, or their own form that includes the following information:

- Presenting problem/reason for admission
- Date of admission
- Admitting diagnosis
- Preliminary treatment plan
- Currently prescribed medications
- Proposed discharge plan
- Behavioral Health Provider contact name and telephone number

Request for PCP response by fax or mail within three business days of the request to include the following health information:

- Status of immunizations
- Date of last visit
- Dates and reasons for any and all hospitalizations
- Ongoing medical illness
- Current medications
- Adverse medication reactions, including sensitivity and allergies
- History of psychopharmacological trials
- Any other medically relevant information

Outpatient providers' compliance with communication standards is monitored

- Medications
- Discharge plan
- Aftercare services for each type, including:
  - Name of Provider
  - Date of first appointment
  - Recommended frequency of appointments
  - Treatment plan

Inpatient and diversionary Providers should make every effort to provide the same notifications and information to the Member's outpatient therapist, if there is one.

Acute care Providers' communication requirements are addressed during continued stay and discharge reviews and documented in Beacon's Member record.

TABLE 3-3: COMMUNICATION BETWEEN BEHAVIORAL HEALTH PROVIDERS AND OTHER TREATERS	
through requests for authorization submitted by the Provider, and through chart reviews	

State Specific ICP and Demonstration Model of Care Requirements
Providers must follow the procedures below as per State guidelines:

- Facilitate referral of the Member to specialists or specialty care, behavioral healthcare services health education classes and community resource agencies, when appropriate
- Integrate medical screening along with basic primary care services provided to demonstration and ICP Members; provide screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders
- Deliver evidence-based behavioral health treatment and establish protocols for referral to behavioral health specialty Providers
- Ensure confidentiality of Members' medical and behavioral health and personal information as required by State and Federal laws

Transitioning Members from One Behavioral Health Provider to Another
If a Member transfers from one behavioral health Provider to another, the transferring Provider must communicate the reason(s) for the transfer along with the information above (as specified for communication from behavioral health Provider to PCP), to the receiving Provider. Routine outpatient behavioral health treatment by an out-of-network Provider is not an authorized service covered by Beacon. Members may be eligible for transitional care within 30 days after joining the Health Plan, or to ensure that services are culturally and linguistically sensitive, individualized to meet the specific needs of the Member, timely per Beacon's timeliness standards, and/or geographically accessible.

Follow-Up after Behavioral Health Hospitalization
All inpatient Providers are required to coordinate after-care appointments with community based Providers prior to the Member's discharge. Beacon's UM and care management staff can assist Providers in determining if the Member is actively engaged in treatment with a behavioral health Provider and assist with referrals to ensure that Members are discharged with a scheduled appointment. Members discharged from inpatient levels-of-care are scheduled for follow-up appointments within seven days of discharge from an acute care setting. Providers are responsible for seeing Members within that time frame and for reaching out to Members who miss their appointments within 24 hours of the missed appointment to reschedule. Beacon's care managers and aftercare coordinators assist in this process by sending reminders to Members; working to remove barriers that may prevent a Member from keeping his or her discharge appointment and coordinating with treating Providers. Network Providers are expected to aid in this process as much as possible to ensure that Members have the supports they need to maintain placement in the community and to prevent unnecessary readmissions.

Reportable Incidents and Events
Beacon requires that all Providers report adverse incidents, other reportable incidents and sentinel events involving the Humana Members to Beacon as follows by calling 1-855-481-7044.

TABLE 3-4: REPORTABLE INCIDENTS			
	Adverse Incidents	**Sentinel Events**	**Other Reportable Incidents**
Incident/Event Description:	An adverse incident is an occurrence that represents actual or potential serious harm to the wellbeing of a Health Plan Member who is currently receiving or has been recently discharged from behavioral health services.	A sentinel event is any situation occurring within or outside of a facility that either results in death of the Member or immediately jeopardizes the safety of a Health Plan Member receiving services in any level of care.	An "other reportable incident" is any incident that occurs within a Provider site at any level of care, which does not immediately place a Health Plan Member at risk but warrants serious concern.
Incidents/Events include the following:	• All medico-legal or non-medicolegal deaths • Any Absence Without Authorization (AWA) involving a Member who does not meet the criteria above • Any injury while in a 24-hour program that could or did result in transportation to an acute care hospital for medical treatment or hospitalization	• All medico-legal deaths • Any medico-legal death is any death required to be reported to the Medical Examiner or in which the Medical Examiner takes jurisdiction • Any AWA involving a patient involuntarily admitted or committed and/or who is at high risk of harm to self or others	• Any non-medicolegal death • Any AWA from a facility involving a Member who does not meet the criteria for a sentinel event as described above • Any physical assault or alleged physical assault by or against a Member that does not meet the criteria of a sentinel event • Any serious injury while in a 24 hour program requiring medical treatment,

TABLE 3-4: REPORTABLE INCIDENTS			
	• Any sexual assault or alleged sexual assault • Any physical assault or alleged physical assault by a staff person or another patient against a Member • Any medication error or suicide attempt that requires medical attention beyond general first aid procedures • Any unscheduled event that results in the temporary evacuation of a program or facility (e.g., fire resulting in response by fire department)	• Any serious injury resulting in hospitalization for medical treatment • A serious injury is any injury that requires the individual to be transported to an acute care hospital for medical treatment and is subsequently medically admitted • Any medication error or suicide attempt that requires medical attention beyond general first aid procedures • Any sexual assault or alleged sexual assault • Any physical assault or alleged physical assault by a staff person against a Member • Any unscheduled event that results in the evacuation of a program or facility whereby regular operations will not be in effect by the end of the business	but not hospitalization • A serious injury, defined as any injury that requires the individual to be transported to an acute care hospital for medical treatment and is not subsequently medically admitted • Any unscheduled event that results in the temporary evacuation of a program or facility such as a small fire that requires fire department response. Data regarding critical incidents is gathered in the aggregate and trended on a quarterly basis for the purpose of identifying opportunities for quality improvement

TABLE 3-4: REPORTABLE INCIDENTS			
		day and may result in the need for finding alternative placement options for Members	
Reporting	• Beacon's Clinical Department is available 24 hours a day • Providers must call, regardless of the hour, to report such incidents		
Method	• Providers should direct all such reports to their Beacon clinical manager or UR clinician by phone • In addition, Providers are required to fax a copy of the Adverse Incident Report Form (for adverse and other reportable incidents and sentinel events) to Beacon's Ombudsperson at 1-888-204-5581 • Incident and event reports should not be emailed unless the Provider is using a secure messaging system.		
Prepare to provide the following:	Providers should be prepared to present: • All relevant information related to the nature of the incident • The parties involved (names and telephone numbers) • The Member's current condition		

4. CARE MANAGEMENT

4.1. Care Coordination

Humana's Integrated Management and Chronic Illness program will provide a proactive and comprehensive system of care for enrolled Members living with chronic physical diseases, mental illness, substance use disorders and/or developmental and intellectual disabilities that promotes person-centered, integrated care across the spectrum of medical, behavioral, psycho-social and long-term services and supports. This approach is aimed at eliminating fragmented and often poorly coordinated healthcare and social services that historically plague effective treatment for these individuals and results in poor health status and ineffectual expenditures.

The description below is designed to provide a broad overview of Humana's care management program. Many Members may already receive community-based case management through the Community Mental Health Center network in Illinois. Humana and Beacon will engage existing case managers whenever possible to ensure continuity of care, avoid unnecessary disruption in services and multiple contacts for Members.

The Provider's participation is key and includes the following activities:

- Participation in Interdisciplinary Care Team (ICT) care conferences via phone, through exchange of written communications and possibly in person
- Participation in inbound and outbound communications to foster care coordination
- Promote Healthcare Effectiveness Data and Information Set (HEDIS®) and National Committee for Quality Assurance (NCQA) quality measures
- Provide all medical record documentation and information as requested to support Humana's fulfillment of State and Federal regulatory and accreditation obligations, e.g., HEDIS

Provider's Role and Responsibility in Care Coordination, Care Transitions, Comprehensive Medication Reviews and Preventive Screenings:

- Assure that Members are informed of specific healthcare needs requiring follow-up and that Members receive training in self-care, including medication adherence, and other measures they may take to promote their own health
- Ensure the Member receives appropriate specialty, ancillary, emergency and hospital care when needed, providing necessary referrals and communicating to specialists, hospitalists, and other Providers the Member information that will assist them in consultation and recommending treatments, equipment and/or services for the Member.
- Provide coordination of care for Members who are homebound or have significant mobility limitations to ensure access to care through home visits by nurse practitioners or physicians.
- Track and document appointments, clinical findings, treatment plans and care received by Members referred to specialists, other healthcare Providers or agencies to ensure continuity of care.
- Obtain authorizations and notify Humana for any out-of-network services when an in-network Provider of the specialty in question is not available in the geographical area.
- Work with Humana's Care Coordination team to arrange for a Member to receive a second opinion from a qualified in-network healthcare professional or arrange for the Member to obtain one outside the network, if a qualified in-network Provider is not available.
- Initiate or assist with the discharge or transfer of Members from an inpatient facility to the most medically appropriate level-of-care facility or back to the Member's home or permanent place of domicile; consider the availability of in-network facilities and obtain appropriate authorizations if using out-of-network facilities.
- Support, participate in, and communicate with the ICT, in person and/or in writing, in developing and implementing an individualized plan of care to facilitate effective care coordination.
- Provide timely access to medical records or information for quality management and other purposes, including audits, reviews of Complaints or appeals, HEDIS, and other studies, and promptly respond to recommendations for improvement by developing and enacting a corrective/improvement plan, as appropriate.
- Follow the preventive care guidelines set by the U.S. Preventive Services Task Force, and provide and document the preventive care services required by the NCQA for HEDIS Quality Assurance Reporting Requirements.

Provider Creation and Participation in Individualized Care Plans – The Individualized Care Plan is based on:

- Initial and ongoing HRA and comprehensive assessment results
- Claims history
- Plans developed for each Member by the ICT
- Include Member-driven goals, objectives and interventions
- Address specific services and benefits
- Provide measurable outcomes

Provider Participation as an Integral Member of the ICT:

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

- The Member and/or his or her authorized caregiver
- The Member's physicians and/or nurses
- Humana's care managers and coordinators
- Social workers and community social-service Providers
- Humana's and/or the Member's behavioral health professionals
- Humana's community health educators and resource-directory specialists

The physician-inclusive ICT model supports the following.

The physician's treatment and medication plans:

- The physician's goals via the Humana Cares team of nurses, social workers, pharmacy specialists and behavioral-health specialists
- Member education and enhancement of direct patient-physician communication
- Self-care management and informed healthcare decision-making
- Care coordination and care transitions
- Access and connections to additional community resources and Medicaid services
- Appropriate end-of-life planning

Expected Provider Communications and Reporting:

- Maintain frequent communication, in person or by phone, with the ICT including other Providers of care and services such as specialist physician, hospital and/or ancillary Providers to ensure continuity of care and effective care coordination.
- Immediately report actual or suspected child abuse, elder abuse or domestic violence to the local law enforcement agency by telephone and submit a follow-up written report to the local law enforcement agency within the time frames as required by law.
- Provide all medical record documentation and information as requested to support Humana's fulfillment of State and Federal regulatory and accreditation obligations, e.g., HEDIS, NCQA.

Working with Demonstration and ICP Members with a Mental Health Diagnosis:

- Facilitate referral of the Member to specialists or specialty care, behavioral health care services, health education classes and community resource agencies, when appropriate.
- Integrate medical screening along with basic primary care services provided to Demonstration and ICP Members; Provide screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.
- Deliver evidence-based behavioral health treatment and establish protocols for referral to behavioral health specialty Providers.
- Ensure confidentiality of Members' medical and behavioral health and personal information as required by State and Federal laws.

Understanding Chronic Conditions Prevalent within the Demonstration and ICP Population:

- Multiple chronic conditions increase the risks for poor outcomes such as mortality and functional limitations as well as the risk of high cost services such as hospitalizations and emergency room visits. Evidence proves that preventive care and frequent/consistent care of chronic conditions lowers the advent of major conditions and decreases use of emergency room visits and readmissions.
- Humana's Clinical Practice Guidelines, available to both affiliated and nonaffiliated Providers on Humana's website, adopt relevant, evidence-based medical and behavioral health guidelines (preventive and certain non-preventive acute and chronic conditions) from recognized sources such as professional medical associations, voluntary health organizations and NIH Centers and Institutes.
- Humana provides chronic disease management services and support to promote self-management for individuals with chronic conditions.

State of Illinois Transition of Care Requirements

To meet the transition of care requirements of the State of Illinois, the following procedures will be followed by Humana and Beacon Providers:

- In those instances when the Member's care needs to be transitioned to a new Provider or Providers either during the transition period and once the transition period is over, the Care Coordinator follows the following procedures to ensure the Member receives ongoing care:
- Identify appropriate Providers in the Member's geographic area that meet cultural and linguistic needs
- Review the list of recommended Behavioral Health Providers with the Member
- Encourage Member to select a recommended Behavioral Health Provider, if unable, the Care Coordinator will select
- Assist Member in accessing an appointment with the identified Provider
- Obtain Member permission to share ICP and relevant assessment findings with selected Behavioral Health Provider
- Obtain Member permission for the exchange of relevant health information between new Behavioral Health Provider and PCP and other treaters

4.2. Utilization Management

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

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

- All Mental Health UM decisions are based upon Beacon's Level of Care/Medical Necessity Criteria (LOCC); Substance Abuse level-of-care decisions are made based on the American Society of Addiction Medicine (ASAM) criteria
- Financial incentives based on an individual UM clinician's number of adverse determinations or denials of payment are prohibited
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization

Note that the information in this chapter, including definitions, procedures, and determination and notification time frames may vary for different lines of business based on differing regulatory requirements. Such differences are indicated where applicable.

Community-based Service Providers
All community-based service Providers (Rule 132 Providers) are expected to follow all regulations and guidelines set forth in Rule 59 ILAC 132.

4.3. Level of Care Criteria (LOCC)

Beacon's LOCC are the basis for all Medical Necessity determinations; accessible through eServices, includes Beacon's specific LOCC for Illinois for each level of care. Providers can also contact us to request a printed copy of Beacon's LOCC.

Beacon's LOCC were developed from the comparison of national, scientific and evidence-based criteria sets, including, but not limited to, those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA), Substance Use and Behavioral Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM). They are reviewed and updated annually or more often as needed to incorporate new treatment applications and technologies that are adopted as generally accepted professional medical practice.

Beacon's LOCC are applied to determine appropriate care for all Members. In general, Members are certified only if they meet the specific Medical Necessity criteria for a particular level-of-care. However, the individual's specific needs and the characteristics of the local service delivery system may also be taken into consideration.

4.4. Utilization Management Terms and Definitions

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

TABLE 4-1: UM TERMS AND DEFINITIONS	
Adverse Determination	A decision to deny, terminate or modify (an approval of fewer days, units or another level of care other than was requested, and with which the practitioner does not agree) an admission, continued inpatient stay, or the availability of any other behavioral healthcare service, for: • Failure to meet the requirements for coverage based on Medical Necessity • Appropriateness of healthcare setting and level-of-care effectiveness • Health Plan benefits
Adverse Action	The following actions or inactions by Beacon or the provider organization: 1. Beacon's denial, in whole or in part, of payment for a service failure to provide covered services in a timely manner in accordance with the waiting time standards 2. Beacon's denial or limited authorization of a requested service, including the determination that a requested service is not a covered service 3. Beacon's reduction, suspension, or termination of a previous authorization for a service 4. Beacon's denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute adverse actions, including, but not limited to, denials based on the following: a. Failure to follow prior authorization procedures b. Failure to follow referral rules c. Failure to file a timely claim 5. Beacon's failure to act within the time frames for making authorization decisions

TABLE 4-1: UM TERMS AND DEFINITIONS	
	6. Beacon's failure to act within the time frames for making appeal decisions
Non-Urgent Concurrent Review and Decision	Any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments. A non-urgent concurrent decision may authorize or modify requested treatment over a period of time or a number of days or treatments, or deny requested treatment, in a non-acute treatment setting.
Non-Urgent Pre-Service Review and Decision	Any case or service that must be approved before the Member obtains care or services. A non-urgent pre-service decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment, in non-acute treatment setting.
Post-Service Review and Decision (Retrospective Decision)	Any review for care or services that have already been received. A post-service decision would authorize, modify or deny payment for a completed course of treatment where a pre-service decision was not rendered, based on the information that would have been available at the time of a pre-service review.
Urgent Care Request and Decision	Any request for care or treatment for which application of the normal time period for a non-urgent care decision: • Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on a prudent layperson's judgment • In the opinion of a practitioner with knowledge of the Member's medical condition, would subject the Member to severe pain that could not be adequately managed without the care or treatment that is requested
Urgent Concurrent Review Decision	Any review for a requested extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments in an acute treatment setting, when a Member's condition meets the definition of urgent care, above
Urgent Pre-Service Decision	Formerly known as a precertification decision, any case or service that must be approved before a Member obtains care or services in an inpatient setting, for a Member whose condition meets the definition of urgent care above. An urgent pre-service decision may authorize or modify requested treatment over a period of time

TABLE 4-1: UM TERMS AND DEFINITIONS	
	or number of days or treatments, or deny requested treatment in an acute treatment setting

Authorization Procedures and Requirements
This section describes the processes for obtaining authorization for inpatient, community-based diversionary and outpatient levels of care, and for Beacon's Medical Necessity determinations and notifications. In all cases, the treating Provider, whether admitting facility or outpatient practitioner, is responsible for following the procedures and requirements presented, in order to ensure payment for properly submitted claims.

Administrative denials may be rendered when applicable authorization procedures, including time frames, are not followed. Members cannot be billed for services that are administratively denied due to a Provider not following the requirements listed in this Manual.

Member Eligibility Verification
The first step in seeking authorization is to determine the Member's eligibility. Since Member eligibility changes occur frequently, Providers are advised to verify a Health Plan Member's eligibility upon admission to, or initiation of treatment, as well as on each subsequent day or date of service to facilitate reimbursement for services.

Member eligibility can change, and possession of a Health Plan Member identification card does not guarantee that the Member is eligible for benefits. Providers are strongly encouraged to check Beacon's eServices or by calling IVR at 1-888-210-2018.

4.5. Emergency Services

Definition
Emergency services are those physician and outpatient hospital services, procedures, and treatments, including psychiatric stabilization and medical detoxification from drugs or alcohol, needed to evaluate or stabilize an emergency medical condition. The definition of an emergency is listed in your PSA.

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

Emergency Screening and Evaluation
Plan Members must be screened for an emergency medical condition by a qualified behavioral health professional from the hospital emergency room, mobile crisis team, or by an emergency service program. This process allows Members access to emergency services as quickly as possible and at the closest facility or by the closest crisis team.

After the evaluation is completed, the facility or program clinician should call Beacon to complete a clinical review, if admission to a level of care that requires precertification is needed. The facility/program clinician is responsible for locating a bed, but may request Beacon's assistance. Beacon may contact an out-of-network facility in cases where there is no timely or appropriate placement available within the network. In cases where there is no in-network or out-of-network psychiatric facility available, Beacon will authorize boarding the Member on a medical unit until an appropriate placement becomes available.

Beacon Clinician Availability
All Beacon clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention, triage and referral procedures. Beacon clinicians are available 24 hours a day, seven days a week to receive crisis calls from providers for authorization of inpatient admission. Members or, their guardians in emergency situations are directed to call Humana at 1-855-235-8530.

Disagreement between PA and Attending Physician
For acute services, in the event that Beacon's Physician Advise (PA) and the emergency service physician do not agree on the service that the Member requires, the emergency service physician's judgment shall prevail and treatment shall be considered appropriate for an emergency medical condition, if such treatment is consistent with generally accepted principles of professional medical practice and is a covered benefit under the Member's program of medical assistance or medical benefits. All Beacon clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention, triage and referral procedures.

4.6. Authorization Requirements

For a complete listing of covered services and authorization requirements, please refer to Attachment A.

Outpatient Treatment
Many Humana Members that you treat will have Individualized Care Plans and a care manager. It is critical that you communicate with the care manager about the services you plan to provide so that they can be included in the Member's care plan and be authorized appropriately. The care manager will assist you to optimize the benefits for each Member you treat. While traditional outpatient services do not require prior authorization, our care managers will work with the treating Providers to ensure that the Member is getting the care that he or she needs. Beacon will conduct outlier management of outpatient care in addition to care coordination.

Please refer to your contract for specific information about procedure and revenue codes that should be used for billing. Services that indicate "eRegister" will be authorized via Beacon's eServices portal. Providers will be asked a series of clinical questions to support Medical Necessity for the service requested. If sufficient information is provided to support the request, the service will be authorized. If additional information is needed, the Provider will be prompted to contact Beacon via phone to continue the request for authorization. While Beacon prefer Providers to make requests via eServices, we will work with Providers who do have technical or staffing barriers to requesting authorizations in this way.

Humana.

Authorization decisions are posted on eServices within the decision time frames outlined in Table 4-3. Providers receive an email message alerting them that a determination has been made. Beacon also faxes authorization letters to Providers upon request; however we strongly encourage Providers to use eServices instead of receiving paper notices. Providers can opt out of receiving paper notices on Beacon's eServices portal. All notices clearly specify the number of units (sessions) approved, the time frame within which the authorization can be used, and explanation of any modifications or denials. All denials can be appealed according to the policies outlined in this Manual.

All forms can be found at www.beaconhealthoptions.com.

Inpatient Services

All inpatient services (including inpatient ECT) require telephonic prior-authorization within 24 hours of admission. Providers should call Beacon at 1-855-481-7044 for all inpatient admissions, including detoxification that is provided on a psychiatric floor or in freestanding psychiatric facilities. All other requests for authorization for detoxification should be directed to Beacon at 1-855-481-7044. Continued-stay reviews require updated clinical information that demonstrates active treatment. Additional information about what is required during pre-service and concurrent stay reviews is listed below.

TABLE 4-2: UM REVIEW REQUIREMENTS – INPATIENT AND DIVERSIONARY

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 • DSM diagnosis: All five axes are appropriate; Axis I and Axis V are required. (A provisional diagnosis is acceptable) • Description of precipitating event and current symptoms requiring inpatient psychiatric care	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	Post-service reviews may be conducted for inpatient, diversionary or outpatient services rendered when necessary. To initiate a post-service review, call Beacon. 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 advise completes a clinical review of all available

TABLE 4-2: UM REVIEW REQUIREMENTS – INPATIENT AND DIVERSIONARY		
• Medication history • Substance use 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	• 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)	information, in order to render a decision.

Authorization determinations are based on the clinical information available at the time the care was provided to the Member.
Members must be notified of all pre-service and concurrent denial decisions. The service is continued without liability to the Member until the Member has been notified of the adverse determination. The denial notification letter sent to the Member or Member's guardian, practitioner, and/or Provider includes the specific reason for the denial decision, the Member's presenting condition, diagnosis and treatment interventions, the reason(s) why such information does not meet the Medical Necessity criteria, reference to the applicable benefit provision, guideline, protocol or criterion on which the denial decision was based, and specific alternative treatment option(s) offered by Beacon, if any. Based on State and/or Federal statutes, an explanation of the Member's appeal rights and the appeals process is enclosed with all denial letters. Notice of inpatient authorization is mailed to the admitting facility. Providers can request additional copies of adverse determination letters by contacting Beacon.

Return of Inadequate or Incomplete Treatment Requests
All requests for authorization 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) which 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. Notice of admission or continued stay approval is mailed to the Member or Member's guardian and the requesting facility within the time frames specified later in this chapter.

If the clinical information available does not support the requested level of care, the UR clinician discusses alternative levels of care that match the Member's presenting clinical symptomatology, with the requestor. If an alternative setting is agreed to by the requestor, the revised request is approved. If agreement cannot be reached between the Beacon UR clinician

and the requestor, the UR clinician consults with a Beacon psychiatrist or psychologist advisor (for outpatient services only). All denial decisions are made by a Beacon physician or psychologist (for outpatient services only) advise. The UR clinician and/or Beacon physician advisor offers the treating Provider the opportunity to seek reconsideration if the request for authorization is denied.

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

Termination of Outpatient Care
Beacon requires that all outpatient Providers set specific termination goals and discharge criteria for Members. Providers are encouraged to use the LOCC (accessible through eServices) to determine if the service meets Medical Necessity for continuing outpatient care.

Decision and Notification Timeframes
Beacon is required by the State and Federal governments to render utilization review decisions in a timely manner to accommodate the clinical urgency of a situation. Beacon has adopted the strictest time frame for all UM decisions in order to comply with the various requirements.

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

TABLE 4-3: DECISION AND NOTIFICATION TIME FRAMES

	Type of Decision	Decision Time Frame	Verbal Notification	Written Notification
Pre-Service Review				
Initial Auth for Inpatient Behavioral Health Emergencies	Expedited	Within 30 minutes	Within 30 minutes	Within 24 hours
Initial Auth for Non-Emergent Inpatient Behavioral Health Services	Expedited	Within 2 hours	Within 2 hours	Within 24 hours
Initial Auth for Other Urgent	Urgent	Within 72 hours	Within 72 hours	Within 72 hours

TABLE 4-3: DECISION AND NOTIFICATION TIME FRAMES				
Behavioral Health Services				
Initial Auth for Non-Urgent Behavioral Health Services	Standard	Within 10 calendar days	Within 10 calendar days	Within 10 calendar days
Concurrent Review				
Continued Auth for Inpatient and Other Urgent Behavioral Health Services	Urgent/ Expedited	Within 24 hours	Within 24 hours	Within 3 calendar days
Continued Auth for Non-Urgent Behavioral Health Services	Non-Urgent/ Standard	Within 10 calendar days	Within 10 calendar days	Within 10 calendar days
Post-Service				
Authorization for Behavioral Health Services Already Rendered	Non-Urgent/ Standard	Within 10 calendar days	Within 10 calendar days	Within 10 calendar days

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

Request for Reconsideration of Adverse Determination
If a Health Plan Member or Member's Provider disagrees with a utilization review decision issued by Beacon, the Member, his/her authorized representative, or the Provider may request reconsideration. Please call Beacon promptly upon receiving notice of the denial for which reconsideration is requested.

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

5. PROVIDER APPEALS

Provider Appeals and Grievance Procedures
You have the right to file with Humana:

- A Medical Necessity Appeal Please refer to Humana's Appeals and Grievance Procedures for further information.

You have the right to file with Beacon:

- Contractual Appeals
- Administrative Appeals (i.e., claims appeals)
- Provider Grievances

How to Submit a Provider Appeal

Claims Appeals: Providers can submit claims through our secure Provider Portal, or in writing

Provider Portal: www.beaconhealthoptions.com Click on "tools" and enter the Health Plan name, and then click "Claims"

Writing: Use the "Provider Claim Appeal Request Form" located in this Manual or on our website. Please include:

- The Member's name and Humana Member ID number
- The Provider's name and ID number
- The code(s) and reason why the determination should be reconsidered
- If you are submitting a Timely Filing appeal, you must send proof of original receipt of the appeal by fax or Electronic Data Information (EDI) for reconsideration
- If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification for reversing the determination

Mail: Beacon Health Options
Humana Claims Department
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801-3393

Member Grievance, Appeals and Fair Hearing Requests
Members have the right to file a Grievance or appeal. They also have the right to request a State Hearing once they have exhausted their appeal rights. Please refer to Humana's Member Grievance and Appeals procedures for further information.

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

6. GENERAL CLAIM POLICIES

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

Definition of "Clean Claim"
A clean claim, as discussed in this Provider Manual Appendix, the Provider services agreement, and in other Beacon informational materials, is defined as one that has no defect and is complete including required substantiating documentation of particular circumstance(s) warranting special treatment without which timely payments on the claim would not be possible.

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

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

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

Prohibition of Billing Members
Providers are not permitted to bill Health Plan Members under any circumstances for covered services rendered, excluding copayments when appropriate. See Chapter 1, Prohibition on Billing Members for more information.

Beacon's Right to Reject Claims
At any time, Beacon can return, reject or disallow any claim, group of claims, or submission received pending correction or explanation.

Recoupments and Adjustments by Beacon
Beacon reserves the right to recoup money from Providers due to errors in billing and/or payment, at any time. In that event, Beacon applies all recoupments and adjustments to future claims processed, and reports such recoupments and adjustments on the EOB with Beacon's Record Identification Number (REC.ID) and the Provider's patient account number.

Claim Turnaround Time
All clean claims will be adjudicated within thirty (30) days from the date on which Beacon receives the claim.

Claims for Inpatient Services:

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

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

- Providers are required to submit HIPAA-compliant coding on all claim submissions; this includes the appropriate HIPAA-compliant revenue, DSM, CPT, HCPCS and ICD codes. Providers should refer to exhibit A for a complete listing of contracted, reimbursable procedure codes.
- Beacon accepts only the appropriate ICD diagnosis codes listing approved by CMS and HIPAA. All diagnosis codes submitted on a claim form must be a complete diagnosis code with appropriate check digits.
- Claims for inpatient and institutional services must include the appropriate discharge status code and be billed in accordance with the National Uniform Billing Committee (NUBC) standards.

* All UB-04 claims must include the 3-digit bill type code and be billed in accordance with the National Uniform Billing Committee (NUBC) standards.

Modifiers
Modifiers can reflect the discipline and licensure status of the treating practitioner or are used to make up specific code sets that are applied to identify services for correct payment. Table 6-1 lists some HIPAA-compliant modifiers accepted by Beacon. Please see your Behavioral Health Services Agreement for Modifiers that are included in your contract.

TABLE 6-1: MODIFIERS			
HIPAA Modifier	**Modifier Description**	**HIPAA Modifier**	**Modifier Description**
AH	Clinical psychologist	HR	Family/couple with client present
AJ	Clinical social worker	HS	Family/couple without client present
HB	Adult program, non-geriatric	HU	Funded by child welfare agency
HC	Adult program, geriatric	HW	Funded by State BH agency
HD	Pregnant/parenting women's program	HX	Funded by county/local agency
HE	Behavioral health program	SA	Nurse practitioner (This modifier required when billing 90862 performed by nurse practitioner)
HF	Substance use program	SE	State and/or Federally funded program/service
HG	Opioid addiction treatment program	TD	Registered nurse
HH	Integrated behavioral health/ substance use program	TF	Intermediate level of care
HI	Integrated behavioral health and mental retardation/developmental disabilities program	TG	Complex/high level of care
HK	Specialized behavioral health programs for high-risk populations	TJ	Program group, child, and/or adolescent
HM	Less than bachelor degree level	UK	Service provided on behalf of the client to someone other than the client-collateral relationship
HN	Bachelor's degree level	U3	Psychology intern
HO	Master's degree level	U4	Social work intern

TABLE 6-1: MODIFIERS			
HP	Doctoral level	U6	Psychiatrist (This modifier required when billing for 90862 provided by psychiatrist)
HQ	Group setting	UD	Substance abuse service

Time Limits for Filing Claims
Bacon must receive claims for covered services within the designated filing limit:

- Within 60 days of the dates of service on outpatient claims
- Within 60 days of the date of discharge on inpatient claims

Providers are encouraged to submit claims as soon as possible for prompt adjudication. Claims submitted after the 60-day filing limit will be denied unless submitted as a waiver or reconsideration request, as described in this chapter.

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

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

7. PROVIDER EDUCATION AND OUTREACH

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

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

How the Program Works

- A quarterly approval report is generated that lists the percentage of claims paid in relation to the volume of claims submitted.
- All Providers below 75 percent approval rate have an additional report generated listing their most common denials and the percentage of claims they reflect.
- An outreach letter is sent to the Provider's billing director as well as a report indicating the top denial reasons. A contact name is given for any questions or to request further assistance or training.

Claim Inquiries and Resources
Additional information is available through the following resources:

Online at www.baconhealthoptions.com:

- Chapter 6 of this Manual
- Beacon's Claims Page
- Read About eServices
- eServices User Manual
- Read About EDI
- EDI Transactions – 837 Companion Guide
- EDI Transactions – 835 Companion Guide

Email Contact
- provider.relations@beaconhealthoptions.com
- edi.operations@beaconhealthoptions.com

Telephone
- Interactive Voice Recognition (IVR): 1-888-210-2018
  You will need your practice or organization's tax ID, the Member's identification number and date of birth, and the date of service.

- Claims Hotline: 1-888-249-0478
  Hours of operation are 8:30 a.m. – 5:30 p.m., Monday – Thursday, 9 a.m. – 5 p.m. Friday

- Beacon's Main Telephone Numbers

Provider Relations	1-855-481-7044
EDI	1-855-481-7044
TTY	1-855-539-5884
FAX	1-855-371-9232

Electronic Media Options
Providers are expected to complete claim transactions electronically through one of the following, where applicable:

- Electronic Data Interchange (EDI) supports electronic submission of claim batches in HIPAA-compliant 837P format for professional services and 837I format for institutional

services. Providers may submit claims using EDI/837 format directly to Beacon or through a billing intermediary. If using Emdeon as the billing intermediary, two identification numbers must be included in the 837 file for adjudication:
    - Beacon's payor ID is 43324; and
    - Beacon's Health Plan-specific ID045.
- eServices enables Providers to submit inpatient and outpatient claims without completing a CMS-1500 or UB-04 claim form. Because much of the required information is available in Beacon's database, most claim submissions take less than one minute and contain few, if any errors.
- IVR provides telephone access to Member eligibility, claim status and authorization status.

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

TABLE 7-1: CLAIM TRANSACTION OVERVIEW

Transaction	Access On:			Applicable When:	Time Frame For Receipt By Beacon	Other Information
	EDI	eServices	IVR			
Member Eligibility Verification	Y	Y	Y	Completing any claim transaction; and Submitting clinical authorization requests	N/A	N/A
Submit Standard Claim	Y	Y	N	Submitting a claim for authorized, covered services, within the timely filing limit	Within 180 days after the date of service	N/A
Resubmission of Denied Claim	N	N	N	A claim being submitted for the first time will be	Within 180 days from the	Waiver requests will be considered only

TABLE 7-1: CLAIM TRANSACTION OVERVIEW						
Transaction	**Access On:**			**Applicable When:**	**Time Frame For Receipt By Beacon**	**Other Information**
	EDI	**eServices**	**IVR**			
				received by Beacon after the original 180-day filing limit, and must include evidence that one of the following conditions is met: ▪ Provider is eligible for reimbursement retroactively ▪ Member was enrolled in the Health Plan retroactively ▪ Services were authorized retroactively ▪ Third party coverage is available and was billed first (A copy of the other insurance's explanation of benefits or payment is required)	qualifying event	for these three circumstances. A waiver request that presents a reason not listed here, will result in a claim denial on a future EOB. A claim submitted beyond the filing limit that does not meet the above criteria may be submitted as a reconsideration request. Beacon's waiver determination is reflected on a future EOB with a message of Waiver Approved or Waiver Denied: if waiver of the filing limit is approved, the claim appears adjudicated; if the request is denied, the

TABLE 7-1: CLAIM TRANSACTION OVERVIEW						
Transaction	**Access On:**			**Applicable When:**	**Time Frame For Receipt By Beacon**	**Other Information**
	EDI	**eServices**	**IVR**			
						denial reason appears.
Request for Reconsideration of Timely Filing Limit*	Y	N	Y	Claim falls outside of all time frames and requirements for resubmission, waiver, and adjustment	Within 180 days from the date of payment or non-payment	Future EOB shows "Reconsideration Approved" or "Reconsideration Denied" with denial reason.
Request to Void Payment	N	N	N	Claims was paid to provider in error Provider needs to return the entire paid amount to Beacon	N/A	***Do NOT send a refund check to Beacon.***
Request for Adjustment (Corrected Claims)	Y	Y	N	The amount paid to provider on a claim was incorrect Adjustment may be requested to correct: ▪ Underpayment (positive request) ▪ Overpayment (negative request)	Positive request must be received by Beacon within 180 days from the date of original payment. No filing limit applies to	Do NOT send a refund check to Beacon. A Rec ID is required to indicate that claim is an adjustment. Adjustments are reflected on a future EOB as recoupment of the previous (incorrect)

TABLE 7-1: CLAIM TRANSACTION OVERVIEW						
Transaction	**Access On:**			**Applicable When:**	**Time Frame For Receipt By Beacon**	**Other Information**
	EDI	**eServices**	**IVR**			
					negative requests.	amount, and if money is owed to provider, repayment of the claim at the correct amount. If an adjustment appears on an EOB and is not correct, another adjustment request may be submitted based on the previous incorrect adjustment. Claims that have been denied cannot be adjusted, but may be resubmitted.
Obtain Claim Status	N	Y	Y	Available 24/7 for all claims transactions submitted by provider	N/A	Claim status is posted within 48 hours after receipt by Beacon.
View/Print Remittance Advice (RA)	N	Y	N	Available 24/7 for all claim transactions	N/A	Printable RA is posted within 48 hours after

TABLE 7-1: CLAIM TRANSACTION OVERVIEW						
Transaction	Access On:			Applicable When:	Time Frame For Receipt By Beacon	Other Information
	EDI	eServices	IVR			
				received by Beacon		receipt by Beacon.

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

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

For paper submissions, Providers are required to submit clean claims on the National Standard Format CMS-1500 or UB-04 claim form. No other forms are accepted.

Paper claim submission must be done using the most current form version as designated by the Centers for Medicare & Medicaid Services (CMS), National Uniform Claim Committee (NUCC). We cannot accept handwritten claims or SuperBills.

Detailed instructions for completing each form type are available at the websites below.

- CMS-1500 Form Instructions www.cms.hhs.gov/transmittals/downloads/R1104CP.pdf
- UB-04 Form Instructions: www.nucc.org

Mail paper claims to: Beacon Health Options
Humana Claims Department
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801-3393

Beacon does not accept claims transmitted by fax.

Paper Resubmission

Beacon Discourages Paper Transactions
BEFORE SUBMITTING PAPER CLAIMS, PLEASE REVIEW ELECTRONIC OPTIONS EARLIER IN THIS CHAPTER.

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

- See Table 7-1 for an explanation of claim resubmission, when resubmission is appropriate, and procedural guidelines.
- If the resubmitted claim is received by Beacon more than 180 days from the date of service. The REC.ID from the denied claim line is required and may be provided in either of the following ways:
    - Enter the REC.ID in box 64 on the UB-04 claim form, or in box 19 on the CMS-1500 form.
    - Submit the corrected claim with a copy of the EOB for the corresponding date of service; or
- The REC.ID corresponds with a single claim line on the Beacon EOB. Therefore, if a claim has multiple lines there will be multiple REC.ID numbers on the Beacon EOB.
- The entire claim that includes the denied claim line(s) may be resubmitted regardless of the number of claim lines; Beacon does not require one line per claim form for resubmission. When resubmitting a multiple-line claim, it is best to attach a copy of the corresponding EOB.
- Resubmitted claims cannot contain original (new) claim lines along with resubmitted claim lines.
- Resubmissions must be received by Beacon within 180 days after the date on the EOB. A claim package postmarked on the 180th day is not valid.
- If the resubmitted claim is received by Beacon within 180 days from the date of service, the corrected claim may be resubmitted as an original. A corrected and legible photocopy is also acceptable.

Paper Submission of 180-day Waiver

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

    Beacon Health Options
    Claim Department/Waivers
    500 Unicorn Park Drive, Suite 401
    Woburn, MA 01801-3393

Completion of the Waiver Request Form
To ensure proper resolution of your request, complete the 180-day waiver request form as accurately and legibly as possible.

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

2. **Provider ID Number**
   Enter the Provider ID Number of the Provider who provided the service(s).

3. **Member Name**
   Enter the Member's name.

4. **Health Plan Member ID Number**
   Enter the Plan Member ID Number.

5. **Contact Person**
   Enter the name of the person whom Beacon should contact if there are any questions regarding this request.

6. **Telephone Number**
   Enter the telephone number of the contact person.

7. **Reason for Waiver**
   Place an "X" on all the line(s) that describe why the waiver is requested.

8. **Provider Signature**
   A 180-day waiver request cannot be processed without a typed, signed, stamped, or computer-generated signature. Beacon will not accept "Signature on file."

9. **Date**
   Indicate the date that the form was signed.

Paper Request for Adjustment or Void

Beacon Discourages Paper Transactions
BEFORE SUBMITTING PAPER CLAIMS, PLEASE REVIEW ELECTRONIC OPTIONS EARLIER IN THIS CHAPTER.

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

- See Table 7-1 for an explanation of adjustments and voids, when these requests are applicable, and procedural guidelines;
- **Do not send a refund check to Beacon.** A Provider who has been incorrectly paid by Beacon must request an adjustment or void;

- Prepare a new claim as you would like your final payment to be, with all required elements; place the Rec.ID in box 19 of the CMS-1500 claim form, or box 64 of the UB04 form or;
- Download and complete the Adjustment/Void Request Form per the instructions below;
- Attach a copy of the original claim;
- Attach a copy of the EOB on which the claim was paid in error or paid an incorrect amount;
- Send the form, documentation and claim to:
  Beacon Health Options
  Claim Departments – Adjustment Requests
  500 Unicorn Park Drive, Suite 401
  Woburn, MA 01801-3393

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

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

2. **Provider ID Number**
   Enter the Beacon Provider ID Number of the Provider that was paid for the service. If the claim was paid under an incorrect Provider number, the claim must be voided and a new claim must be submitted with the correct Provider ID Number.

3. **Member Name**
   Enter the Member's name as it appears on the EOB. If the payment was made for the wrong Member, the claim must be voided and a new claim must be submitted.

4. **Member Identification Number**
   Enter the Plan Member ID Number as it appears on the EOB. If a payment was made for the wrong Member, the claim must be voided and a new claim must be submitted.

5. **Beacon Record ID number**
   Enter the record ID number as listed on the EOB.

6. **Beacon Paid Date**
   Enter the date the check was cut as listed on the EOB.

7. **Check Appropriate Line**
   Place an "X" on the line that best describes the type of adjustment/void being requested.

8. **Check All that Apply**
   Place an "X" on the line(s) which best describe the reason(s) for requesting the adjustment/void. If "Other" is marked, describe the reason for the request.

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

10. **Date**
    List the date that the form is signed.

8. PROVIDER EDUCATION AND COMPLIANCE-BASED MATERIALS

Providers are expected to adhere to all training programs identified as compliance-based training by Humana and Beacon. This includes agreement and assurance that all affiliated Participating Providers and staff members are trained on the identified compliance material. This includes the following training modules:

- Provider Orientation
- Medicaid Provider Orientation
- Cultural Competency (required annually)
- Health, Safety and Welfare Education (required annually)
- Fraud, Waste and Abuse Detection, Correction and Prevention (required annually)

For information on Humana’s Cultural Competency Plan, see Section I – General Provider Information, subsection 12.