Behavioral Health Policy and Procedure Manual for Providers

Well Sense Health Plan

This document contains chapters 1-7 of Beacon's Behavioral Health Policy and Procedure Manual for providers serving Well Sense Health Plan members. All referenced materials are available on Beacon's website. Chapters that contain all level of care service descriptions and criteria will be posted on eServices. To obtain a copy, please email provider.relations@beaconhealthoptions.com or call (855) 834-5655.

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

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Chapter 1

Introduction

1.1. Beacon/Well Sense Health Plan Partnership

1.2. About this Provider Manual

1.3. Introduction to Well Sense Health Plan

1.4. Introduction to Beacon

1.5. Beacon/Well Sense Health Plan Behavioral Health Program

1.6. Additional Resources and Information

1.1. Beacon/Well Sense Health Plan Partnership

Well Sense Health Plan (Well Sense) has contracted with Beacon Health Strategies LLC (Beacon), a Beacon Health Options company, to manage the delivery of behavioral health and substance use disorder services for Well Sense members covered by the following products:

- Medicaid
- Medicare Advantage

The Plan delegates the following areas of responsibility to Beacon:

1. Claims Processing and Claims Payment
2. Member Rights and Responsibilities
3. Provider Contracting
4. Provider Credentialing and Recredentialing
5. Quality Management and Improvement
6. Referral and Triage
7. Service Accessibility and Availability
8. Service Authorization
9. Treatment Record Compliance
10. Utilization Management/Case Management

1.2. About this Provider Manual

This Behavioral Health Provider Policy and Procedure Manual (hereinafter, the "Manual") is a legal document incorporated by reference as part of each provider's provider services agreement with Beacon.

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

Chapter 7 covers billing transactions. Beacon's level of care criteria (LOCC) are presented separately in Appendix B, accessible through eServices or by calling Beacon. Additional information is provided in the following appendices below:

- Appendix A: Links to Clinical and Quality Forms
- Appendix B: Level of Care Criteria (available on eServices)

The Manual is posted on Beacon's website, www.beaconhealthoptions.com and on Beacon's eServices; only the version on eServices includes Beacon's LOCC. Providers may request a printed copy of the Manual by calling Beacon at 855.834.5655.

Updates to the Manual as permitted by the Provider Services Agreement (PSA) are posted on Beacon's website, and notification may be sent by postal mail and/or electronic mail. Beacon provides notification to network providers at least 60 days prior to the effective date of any policy or procedural change that impacts a provider, such as modification in payment or covered services. Beacon provides 60 days' notice unless the change is a state or federal mandated requirement.

1.3. Introduction to Well Sense Health Plan

Well Sense Health Plan (Well Sense) is a managed care organization (MCO) that has contracted with the New Hampshire Department of Health and Human Services to provide medical insurance coverage to New Hampshire residents who are eligible for Medicaid and enrolled in our managed care plan (Plan). The Plan is operated by Boston Medical Center Health Plan, Inc., which is an affiliate of Boston Medical Center and does business in New Hampshire under the name Well Sense Health Plan.

1.4. Introduction to Beacon

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

Presently, the Beacon family of companies serves more than 50 million individuals on behalf of more than 350 client organizations across the country. Most often co-located at the physical location of our plan partners, Beacon's "in-sourced" approach deploys utilization managers, case managers, and provider network professionals into each local market where Beacon conducts business. Working closely with our plan partner, this approach facilitates better coordination of care for members with physical, behavioral, and social conditions and is designed to support a "medical home" model.

Quantifiable results prove that this approach improves the lives of individuals and their families and helps plans to better integrate behavioral health with medical health.

1.5. Beacon/Well Sense Behavioral Health Program

The Well Sense/Beacon behavioral health and substance use disorder (BH/SU) program provides members with access to a full continuum of covered behavioral health and substance use disorder services through Beacon's network of contracted providers. The primary goal of the program is to provide medically necessary care in the most clinically appropriate and cost-effective therapeutic settings. By ensuring that all plan members receive timely access to clinically appropriate behavioral healthcare services, Well Sense and Beacon believe that quality clinical services can achieve improved outcomes for our members.

Unique populations covered/service offered

Well Sense Health Plan covers New Hampshire Medicaid-eligible members who choose Well Sense, which includes the Granite Advantage HealthCare Program members..

1.6. Additional Resources and Information

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

1. Go to the Provider Tools page of the website for detailed information about working with Beacon, frequently asked questions, clinical articles, clinical practice guidelines, and links to additional resources.
2. Log on to eServices (https://providerportal.beaconhealthoptions.com/) to check member eligibility and number of visits available, submit claims and authorization requests, view claims and authorization status, view/print claims reports, update practice information, and use other electronic tools for communication and transactions with Beacon.
3. Email provider.relations@beaconhealthoptions.com.
4. Beacon contact information is available on Beacon's website (www.beaconhealthoptions.com) or call (855) 834-5655 to speak with a Beacon representative.

Chapter 2

Medicare and Medicaid Requirements

2.1. About this Chapter

2.2. Provider Requirements

About this Chapter

This chapter sets forth provisions applicable to all services provided to all Medicare Advantage members, members covered by both Medicare and Medicaid (Duals), and to Medicaid members to the extent that a state has adopted the federal requirements referenced in this chapter as part of its Medicaid program.

These terms are intended to supplement the Medicare Advantage and Medicaid requirements found in the Provider Services Agreements (PSAs) of providers participating in the Medicare Advantage and Medicaid products. In the event of a conflict between the provisions in this chapter and provisions found elsewhere in the manual, the provisions of this chapter shall govern with respect to Medicare Advantage members, Medicaid members, and Duals.

The provisions of this chapter are required by the Centers for Medicare and Medicaid (CMS), and as such, they may be updated, supplemented and amended from time to time to comply with CMS requirements. Citations to federal laws and regulations are provided for informational purposes only and are deemed to include any successor laws or regulations.

Provider Requirements

As a provider contracted to provide services to Medicare Advantage and/or Medicaid1[1] members under a PSA, the provider shall:

- Not distribute any marketing materials, as such term is defined in 42 CFR Section 422.2260, to Medicare Advantage members or prospective Medicare Advantage members unless such materials have received the prior written approval of: (a) Beacon and, if required, (b) CMS and/or the applicable Plan. The provider shall further not undertake any activity inconsistent with CMS marketing guidelines as in effect from time to time. [42 CFR 422.2260, et seq.]
- Ensure that covered services are provided in a culturally competent manner. [42 CFR 422.112(a)(8)]
- Maintain procedures to inform Medicare Advantage members of follow-up care and, if applicable, provide training in self-care as necessary. [42 CFR 422.112(b)(5)]
- Document in a prominent place in the medical record of Medicare Advantage members if the member has executed an advance directive. [42 CFR 422.128 (b)(1)(ii)(e)]
- Provide continuation of care to Medicare Advantage members in a manner and according to time frames set forth in the PSA, and if CMS imposes additional continuation of care criteria or time frames applicable to Medicare Advantage members, the provider shall comply with such additional CMS requirements as well as any requirements set forth in the PSA. [42 CFR 422.504(g)(2)(i) and (ii) and 42 CFR 422.504(g)(3)]
- In the event that the provider provides influenza and/or pneumococcal vaccines to patients, for any Medicare Advantage member, the provider shall provide such vaccines to Medicare Advantage members with no cost sharing. [42 CFR 422.100(g)(1) and (2)]
- Not discriminate against any Medicare Advantage member based upon the member's health status. [42 CFR 422.110(a)]
- Be accessible to Medicare Advantage members 24 hours per day, seven days per week when medically necessary. [42 CFR 422.112(a)(7)]
- Comply, as set forth in the PSA, with all applicable federal laws, including but not limited to, those federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse such as the False Claims Act and the federal anti-kickback statute. [42 CFR 422.504(h)(1)]

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[1] *Providers contracted to provide services to Medicaid members who are not also covered by Medicare shall comply with the requirements set forth above to the extent that a state has adopted the requirements as part of its Medicaid program.*

- Agree that Beacon and/or the applicable plan may notify all impacted Medicare Advantage members of the termination of the provider's participation in Beacon or the plan's provider network, as applicable. [42 CFR 422.111(e)]
- Disclose to CMS and to Beacon or the plan, quality and performance indicators, including disenrollment rates, member satisfaction rates and health outcomes to enable the plan to satisfy applicable CMS reporting requirements. [42 CFR 422.504 (f)(2)(iv)(A), (B), and (C)]
- Safeguard the privacy of any information that identifies a particular Member and maintain records in an accurate and timely manner. [42 CFR 422.118]
- Maintain and distribute to all employees and staff written standards of conduct that clearly state the provider's commitment to comply with all applicable statutory, regulatory, and Medicare program requirements (Code of Conduct) and require all employees and staff to certify that they have read, understand, and agree to comply with the standards. Require employees and staff to certify that in administering or delivering Medicare benefits, they are free of any conflict of interest as set forth in the provider's conflict of interest policy. [42 CFR 422.503(b)(4)(vi)(A), (E), and (F)] (Beacon may request annual certifications and documentation necessary to satisfy a regulatory audit of Beacon or the plan.)
- Comply with the requirements of the compliance programs (which include measures to prevent, detect, and correct Medicare non-compliance as well as measures to prevent, detect, and correct fraud, waste, and abuse) of plans that are Part C and Part D sponsors. Comply with and participate in, and require employees and staff to comply with and participate in, training and education given as part of the plan's compliance plan to detect, correct, and prevent fraud, waste, and abuse. [42 C.F.R. §422.503 and 42 C.F.R. §423.504]
- Monitor employees and staff on a monthly basis against the List of Excluded Individuals and Entities posted by the Office of the Inspector General of the Department of Health and Human Services and any applicable State Office of the Inspector General on their respective websites, the Excluded Parties List System, and the System for Award Management. [42 CFR 422.503(b)(4)(vi)(F)]
- Provide Beacon with written attestations documenting satisfaction of the requirements set forth above specific to the provider's Code of Conduct, compliance with the plan's fraud, waste, and abuse training, and the performance of monthly monitoring of employees and staff. [42 CFR 422.503(b)(4)(vi)(A), (C), and (D)]

The provider further acknowledges that:

- Beacon and/or plans may offer benefits in a continuation area for the members who move permanently out of the plan's service area. [42 CFR 422.54(b)]
- Beacon and/or plans will make timely and reasonable payment to, or on behalf of, a Medicare Advantage member for emergency or urgently needed services obtained by a member from a non-contracted provider or supplier to the extent provided by 42 CFR 422.100(b)(1)(ii).
- Though it may not be applicable to the services provided by the provider, the plan will make available, through direct access and/or without member cost share as, and to the extent required by CMS, out-of-area renal dialysis services and certain other services, such as mammography, women's preventive services and certain vaccines. [42 CFR 422.100(b)(1)(iv), 42 CFR 422.100(g)(1) and (2)]

Chapter 3

Provider Participation in Beacon's Behavioral Health Services Network

3.1. Network Operations

3.2. Contracting and Maintaining Network Participation

3.3. Transactions and Communications with Beacon

3.4. Access Standards

3.5. Beacon's Provider Database

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

3.7. Adding Sites, Services, and Programs

3.8. Provider Credentialing and Recredentialing

3.9. Prohibition on Billing Members

3.10. Additional Regulations

3.1 Network Operations

Beacon's Network Operations Department, with Provider Relations, is responsible for procurement and administrative management of Beacon's behavioral health provider network. As such, their role includes contracting, credentialing, and provider relations functions. Representatives may be reached by emailing provider.relations@beaconhealthoptions.com, or by phone between 8:30 a.m. and 6 p.m., Eastern Time (ET) Monday through Thursday, and 8:30 a.m. to 5 p.m., ET on Fridays. Contact Beacon at (855) 834-5655 and choose option #2.

3.2 Contracting and Maintaining Network Participation

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

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

3.3 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 providers. As described below, eServices and EDI are also accessed through the website.

Electronic media

Beacon provides three tools to streamline providers' business interactions with Beacon:

1. **eServices**

   eServices, Beacon's secure Web portal, supports all provider transactions while saving providers' time, postage expense, billing fees, and reducing paper waste. eServices is a service provided at no cost to contracted providers and is accessible through www.beaconhealthoptions.com 24 hours a day, seven days a week.

   In the process of claims submission, 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. For provider convenience, all electronic 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 controls what users can access with each eServices feature.

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

2. **Electronic data interchange**

Electronic data interchange (EDI) is available to providers to verify Beacon member eligibility and for electronic claim submission directly to Beacon or via an intermediary. For information regarding EDI set-up and testing, please download Beacon's 837 and 835 companion guides.

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

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

Table 3-1: Electronic Transactions Availability

Transaction/Capability	Available 24/7 on:	
	eServices	EDI
Verify member eligibility, benefits, and co-payments	Yes	Yes (HIPAA 270/271)
Check number of visits available	Yes	Yes (HIPAA 270/271)
Submit authorization status	Yes	No
View authorization status	Yes	No
Update practice information	Yes	No
Submit claims	Yes	Yes (HIPAA 837)
Upload EDI claims to Beacon and view EDI upload history	Yes	Yes (HIPAA 837)
View claims status and print EOBs	Yes	Yes (HIPAA 835)
Print claims reports and graphs	Yes	No
Download electronic remittance advice	Yes	Yes (HIPAA 835)
EDI acknowledgement and submission reports	Yes	Yes (HIPAA 835)
Pend authorization requests for internal approval	Yes	No
Access Beacon's level of care criteria and provider manual	Yes	No

Email

Beacon encourages providers to communicate with Beacon by email addressed to provider.relations@beaconhealthoptions.com using your resident email program or internet mail application. Beacon sends provider alerts related to regulatory requirements, protocol changes, helpful reminders regarding claim submission, etc. 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

To ensure compliance with HIPAA requirements, providers are reminded that personal health information (PHI) may not be communicated via email. Beacon's eServices site is a secure site for sharing of PHI information. PHI may be communicated by telephone or secure fax.

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

3.4 Access Standards

Table 3-2: Service Availability and Hours of Operation

Type of Appointment/ Service	Appointment Must be Offered:
General Appointment Standards	
Routine/Non-Urgent Services	Within 10 business days
Urgent Care	Within 48 hours
Emergency Services	Immediately; 24 hours a day, seven days a week
Aftercare Appointment Standards *Inpatient and 24-hour diversionary service must schedule an aftercare follow-up prior to a member's discharge. Appointments for discharges from NH Hospital must be scheduled within 7 calendar days of discharge.*	
Non-24-hour Diversionary	Within 2 calendar days
Transitional Healthcare	Within 2 business days
Psychopharmacology Services/ Medication Management	Within 7 calendar days
All Other Outpatient Services	Within 7 calendar days
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 a day, seven days a week. ▪ Outpatient facilities, physicians, and practitioners are expected to provide these services during operating hours. ▪ After hours, providers should have a live telephone answering 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.

Type Of Appointment/ Service	Appointment Must Be Offered:
Outpatient Services	▪ Outpatient providers should have services available Monday through Friday, from 9 a.m. to 5 p.m. ▪ Evening and/or weekend hours should also be available at least two days per week.
Interpreter Services	▪ Under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency.
Substance Use Disorder (SUD) Services	
Response Time for Agencies under Contract	▪ Agencies under contract with managed care organizations (MCOs) as “SUD Outpatient Programs” and “SUD Comprehensive Programs” respond to inquiries for SUD services from members or referring agencies as soon as possible and no later than two business days following the day the call was first received.
Initial Eligibility Screening for SUD Services	▪ The SUD provider conducts an initial eligibility screening for services as soon as possible, ideally at the time of first contact (direct communication by phone or in-person) with the member or referring agency, but no later than two business days following the date of first contact.
Members Screening Positive for SUD Services	▪ Members who have screened positive for SUD services receive an SUD assessment and an American Society for Addiction Medicine (ASAM) level of care (LOC) assessment within two business days of the initial eligibility screening and a clinical evaluation as soon as possible following the ASAM LOC assessment and no later than three business days after admission.
Members Identified for Withdrawal Management, Outpatient, or Intensive Outpatient SUD Services	▪ Members identified for withdrawal management, outpatient, or intensive outpatient services start receiving services within seven business days from the date the ASAM LOC assessment was completed.
Members Identified for Partial Hospitalization or Rehabilitative Residential SUD Services	▪ Members identified for partial hospitalization or rehabilitative residential services start receiving interim services (services at a lower level of care than that identified by the ASAM LOC Assessment) or the identified service type within seven business days from the date the initial assessment was completed. They will start receiving the identified level of care no later than 14 business days from the date the initial assessment was completed.

Type Of Appointment/ Service	Appointment Must Be Offered:
Services Not Available within 14 Business Days	If the type of service identified in the ASAM Level of Care Assessment is not available from the provider who conducted the initial assessment within 48 hours, the provider must provide interim SUD services until such a time that the member starts receiving the identified level of care. If the type of service is not provided by the ordering provider, than Beacon can assist in making a closed loop referral for that type of service (for the identified level of care) within 14 business days from initial contact and to provide interim SUD services until such a time that the Member is accepted and starts receiving services by the receiving agency. ▪ When the level of care identified by the initial assessment becomes available by the receiving agency or the agency of the member's choice, members being provided interim services shall be reassessed for ASAM level of care.
Pregnant Women with an ASAM LOC	Pregnant women will be admitted to the identified LOC within 24 hours of the ASAM LOC Assessment. If the contractor is unable to admit a pregnant woman for the needed level of care within 24 hours, the contractor: a. Assists the pregnant woman with identifying alternative providers and with accessing services with these providers. This assistance includes actively reaching out to identify providers on the behalf of the client; and b. Provides interim services until the appropriate LOC becomes available at either the contractor agency or an alternative provider. Interim services include: i. At least one 60-minute individual or group outpatient session per week; ii. Recovery support services as needed by the client; and iii. Daily calls to the client to assess and respond to any emergent needs. Pregnant women seeking treatment shall be provided access to childcare and transportation to aid in treatment participation.

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

3.5 Beacon's Provider Database

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

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

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

3.6 Required Notification of Practice Changes and Limitations in Appointment Access

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

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

Table 3-3: Required Notifications

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

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

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

3.7 Adding Sites, Services, and Programs

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

To add a site, service or program not previously included in the PSA, the provider must notify Beacon in writing (email to provider.relations@beaconhealthoptions.com is acceptable) of the location and capabilities of the new site, service, or program. Beacon will determine whether the site, service, or program meets an identified geographic, cultural/linguistic and/or specialty need in our network and will notify the provider of the determination.

If Beacon agrees to add the new site, service or program to its network, we will advise the provider of applicable credentialing requirements. In some cases, a site visit by Beacon will be required before approval. Site visits occur in accordance with Beacon's credentialing policies and procedures. When the credentialing process is complete, the site, service or program will be added to Beacon's database under the existing provider identification number, and an updated fee schedule will be mailed to the provider.

3.8 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 all requested information within the specified time frame. Private, solo, and group practice clinicians are individually credentialed, while facilities are credentialed as organizations. The processes for both are described below.

To request credentialing information and application(s), please call Beacon's National Provider Services Line (800) 397-1630.

Table 3-4: Credentialing Processes

<table>
<tr><th>Individual Practitioner Credentialing</th><th>Organizational Credentialing</th></tr>
<tr><td>Beacon individually credentials and recredentials the following categories of clinicians in private, solo, or group practice settings:
▪ Psychiatrist
▪ Physician certified in addiction medicine
▪ Psychologist
▪ Licensed clinical social workers
▪ Master's-level clinical nurse specialists certified in behavioral health/psychiatric nurses
▪ Licensed clinical mental health counselors
▪ Licensed marriage and family therapists
▪ Master's-level licensed alcohol and drug counselors (MLADC)
▪ Other behavioral healthcare specialists who are master's level or above and who are licensed, certified, or registered by the state in which they practice</td><td>Beacon credentials and recredentials facilities and licensed outpatient agencies as organizations. Facilities that must be credentialed by Beacon as organizations include:
▪ Licensed outpatient clinics and agencies, including hospital-based clinics
▪ Freestanding inpatient behavioral health facilities – freestanding and within general hospital
▪ Inpatient behavioral health units at general hospitals
▪ Inpatient detoxification facilities
▪ Community Mental Health Centers
▪ Federally Qualified Health Centers SUD outpatient programs
▪ SUD Comprehensive Programs
▪ Other diversionary behavioral health and substance use services, including:
1. Partial hospitalization
2. Day treatment
3. Intensive outpatient
4. Substance use residential</td></tr>
</table>

Individual practitioner credentialing

To be credentialed by Beacon, practitioners must be licensed and/or certified in accordance with state licensure requirements, and the license must be in force and in good standing at the time of credentialing or recredentialing. Providers must be enrolled in NH Medicaid to join the Beacon network in NH.

Practitioners must submit a complete practitioner credentialing application with all required attachments. Incomplete applications cannot be processed. All submitted information is primary-source verified by Beacon; providers are notified of any discrepancies found and any criteria not met.

Providers have the opportunity to submit additional, clarifying information to correct the identified discrepancy. Discrepancies and/or unmet criteria may disqualify the practitioner for network participation.

Once the practitioner has been approved for credentialing and contracted with Beacon as a solo provider, or verified as a staff member of a contracted group practice, Beacon will notify the practitioner or the group practice's credentialing contact of the date on which they may begin to serve members of specified health plans.

Organizational credentialing

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

The credentialed facility is responsible for credentialing and overseeing its clinical staff, as Beacon does not individually credential facility-based staff. Master's-level behavioral health counselors are approved to function in all contracted hospital-based, agency/clinic-based and other facility services sites. Behavioral health program eligibility criteria include the following:

- Master's degree or above in a behavioral health field (including, but not restricted to, counseling, family therapy, psychology, etc.) from an accredited college or university
- An employee or contractor within a hospital or behavioral health clinic licensed in the state of New Hampshire who meets all applicable federal, state, and local laws and regulations; supervised in the provision of services by a licensed independent clinical social worker, a licensed psychologist, a licensed master's-level clinical nurse specialist, or licensed psychiatrist meeting the contractor's credentialing requirements
- State-certified SUD outpatient and SUD comprehensive programs are the only facilities allowed to utilize Licensed Alcohol and Drug Counselors (LADCs) to provide SUD services under the supervision of an MLADC
- Is covered by the hospital or behavioral health/substance use disorder agency's professional liability coverage at a minimum of $1,000,000/$3,000,000
- Absence of Medicare/Medicaid sanctions

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

Recredentialing

All practitioners and organizational providers are reviewed for recredentialing within 36 months of their last credentialing approval date. They must continue to meet Beacon's established credentialing criteria and quality-of-care standards for continued participation in Beacon's behavioral health provider network. Failure to comply with recredentialing requirements, including timelines, may result in removal from the network.

3.9 Prohibition on Billing Members

Health plan members may not be billed for any covered service or any balance after reimbursement by Beacon. Further, providers may not charge Well Sense members for any services that are not deemed medically necessary upon clinical review or that are administratively denied. It is the provider's responsibility to check benefits prior to beginning treatment of this membership and to follow the procedures set forth in this Manual.

3.10 Additional Regulations

1. The MCO shall ensure that all clinicians who provide community mental health services meet the requirements in He-M 401 and He-M 426 and are certified in the use of the New Hampshire version of the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA).
   a. Clinicians shall be certified in the use of the New Hampshire version of the CANS and the ANSA within 120 days of implementation by the Department of Health and Human Services of a web-based training and certification system.
      i. The CANS and the ANSA assessment shall be completed by the community mental health program no later than the first member annual review following clinician certification to utilize the CANS and the ANSA.
      ii. The community mental health long-term care eligibility tool, specified in He-M 401 and in effect on January 1, 2012, shall continue to be used by a clinician until such time as the Department of Health and Human Services implements the web-based access to the CANS and the ANSA; the clinician is certified in the use of the CANS and the ANSA; and the member annual review date has passed.
   b. The CANS and the ANSA assessment shall be completed at least every 90 calendar days to

document progress towards goals and objectives and any continued need for CMH services.

    i. Documentation of the review shall fulfill the quarterly review requirements as defined in He-M 408 and He-M 401.
    ii. The CANS and the ANSA shall be used to assist the clinician and the MCO in developing an individualized, person- centered treatment plan, with measurable outcomes to drive future modifications to the individualized service plan.

2. The MCO shall ensure integrated care coordination by requiring providers to accept all referrals for its members from the MCO that result from a court order or a request from DHHS. The MCO shall be required to pay for these Medicaid state plan services, to include assessment and diagnostic evaluations, for these members. Court ordered treatment services shall be delivered at an appropriate level of care.
3. The aftercare provider is required to conduct a medication reconciliation within 48 business hours of discharge for any member discharged from an acute care setting, including psychiatric hospitalization and residential treatment.
4. Providers in the child and adolescent mental health service delivery system shall collaborate with the adult mental health service delivery system in the transition of members through these systems, through activities such as communicating treatment plans and exchange of information.
5. Prescribers and dispensers shall comply with the NH Prescription Drug Monitoring Program (PDMP) requirements, including but not limited to opioid prescribing guidelines.
6. Providers shall provide to the MCO, to the maximum extent possible, data on substance dispensing to Members prior to releasing such medications to Members.

Chapter 4

Members, Benefits, and Member-Related Policies

4.1. Behavioral Health and Substance Use Disorder Benefits

4.2. Outpatient Benefits

4.3. Member Rights and Responsibilities

4.4. Non-Discrimination Policy and Regulations

4.5. Confidentiality of Member Information

4.6. Well Sense Member Eligibility

4.7. Mental Health Policy

4.1. Behavioral Health and Substance Use Disorder Benefits

Beacon provides behavioral health services as outlined below. These services are subject to modification based on federal and state mandates.

Table 4-1: Behavioral Health Services

Service	Description
Inpatient Mental Health and Substance Use Disorder Services	▪ Medically necessary services for the treatment of mental, emotional, or substance use disorders ▪ Medically necessary inpatient admissions for adults and children to acute care hospitals for psychiatric conditions are a benefit of the Medicaid program and are subject to UR requirements. ▪ Includes inpatient psychiatric services, ordered by a court of competent jurisdiction, relating to court-ordered commitments to psychiatric facilities ▪ Admissions for chronic diagnoses, such as MR or organic brain syndrome, are not a covered benefit for acute care hospitals without an accompanying medical condition. ▪ Medically managed withdrawal management in an acute hospital setting
Outpatient Mental Health and Substance Use Disorder Services	▪ Medically necessary services for the treatment of mental, emotional, or substance use disorders ▪ Outpatient behavioral health services are limited to 24 initial encounters per child (child is defined up until age 18) and 18 initial encounters for adults, per year. These limits do not apply to services rendered by a Community Mental Health Center (CMHC). ▪ Includes outpatient psychiatric services ordered by a court of competent jurisdiction, relating to court-ordered commitments to psychiatric facilities, or placements ▪ Provider types include psychiatrist, psychologist, licensed independent clinical social worker (LICSW), licensed marriage and family therapist (LMFT), licensed clinical mental health counselors (LCMHC), and master's-level licensed alcohol and drug counselors (MLADC). ▪ Does not require a primary care provider referral ▪ Medication management visits do not count against the outpatient visit limit. ▪ Psychological testing is covered for specific diagnosis when medically necessary or when court-ordered. ▪ Psychological testing will be limited to 8 hours of testing per client, per calendar year (any provider). ▪ Psychological testing does count towards outpatient encounter limits. ▪ Substance use disorder screening by behavioral health practitioners

Service	Description
	▪ Opioid treatment programs, including methadone and buprenorphine administration
Professional Services	▪ Services provided by or under the personal supervision of a physician within the physician's scope of practice are covered when reasonable and medically necessary. This includes visits in the office, home, inpatient, or outpatient location under Medicaid guidelines.

4.2. Outpatient Benefits

Access

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

Initial encounters

Members are allowed a fixed number of initial therapy sessions without prior authorization. These sessions, called Initial Encounters (IEs), must be provided by contracted in-network providers, and are subject to meeting medical necessity criteria.

To ensure payment for services, providers are strongly encouraged to ask new patients if they have been treated by other therapists. Via eServices, providers can determine the number of IEs that have been billed to Beacon. However, please note, the member may have used additional visits that have not yet been billed. If the member has used some IEs elsewhere, the new provider is encouraged to obtain authorization prior to treatment.

Table 4-2: Initial Encounters

Outpatient Psychotherapy	Initial Encounters Per Episode Of Care
▪ Psychiatric Diagnostic Evaluation (90791) ▪ Psychiatric Diagnostic Evaluation with Medical Services (90792) ▪ Psychotherapy, 30 minutes (90832) ▪ Psychotherapy, 45 minutes (90834) ▪ Psychotherapy, 60 minutes (90837) ▪ Psychotherapy, 30 minutes Add On (90833) ▪ Psychotherapy, 45 minutes Add One (90836) ▪ Psychotherapy, 60 minutes Add One (90838) ▪ Family psychotherapy (without the patient) 45-60 min (90846) ▪ Family/couple therapy – 60 min (90847)	Count towards initial encounters/additional units requested via eServices
▪ Group therapy (90853) ▪ Outpatient substance abuse therapy ▪ Medication management (E&M)	No authorization required

* ***See Chapter 6 for authorization procedures.***

4.3. Member Rights and Responsibilities

Member rights

Well Sense and Beacon are firmly committed to ensuring that members are active and informed participants in the planning and treatment phases of their behavioral health and substance use disorder services. We believe that members become empowered through ongoing collaboration with their healthcare providers and that collaboration among providers is critical 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. All plan members have the following rights:

Right to Receive Information

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

Right to Respect and Privacy

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

Right to Confidentiality

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

Right to Participate in the Treatment Process

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

Right to Treatment and Informed Consent

Members have the right to give or refuse consent for treatment and for communication to PCPs and other behavioral health providers.

Right to a Second Opinion

Members are entitled to a second opinion, which is provided at no cost to them.

Right to Clinical/Treatment Information

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

Right to Appeal Decisions Made by Beacon

Members and their legal guardian have the right to appeal Beacon's decision to not authorize care at the requested level of care, or Beacon's denial of continued stay at a particular level of care according to the clinical appeals procedures described in Chapter 6. Members and their legal guardians may also request the behavioral health or substance use disorder healthcare provider to appeal on their behalf according to the same procedures.

Right to Submit a Grievance or Concern to Beacon

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

- The quality of care delivered to the member by a Beacon-contracted provider
- The Beacon utilization review process
- The Beacon network of services
- The procedure for filing a grievance as described in Chapter 4

Right to Contact Beacon Ombudsperson

Members have the right to contact Beacon's ombudsperson to obtain a copy of Beacon's Member Rights and Responsibilities statement. The Beacon ombudsperson may be contacted at (855) 834-5655 or by TTY at711.

Right to Make Recommendations about Member Rights and Responsibilities

Members have the right to make recommendations directly to Beacon regarding Beacon's Member 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.

If the member declines interpretation services at no cost to the member, the provider must inform the member of the potential consequences of declining the services, with the assistance of a competent interpreter to ensure the member's understanding. The provider must then document that the member declined interpretation services. Interpreter services must be re-offered at every new contact. Every decline of services requires new documentation of the offer and the subsequent decline. Children may not be used for interpretation.

Member responsibilities

Members of the health plan agree to do the following:

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

Posting member rights and responsibilities

All contracted providers must display in a highly visible and prominent place a statement of members' rights and responsibilities. This statement must be posted and made available in languages consistent with the demographics of the population(s) served. This statement can either be Beacon's statement or a comparable statement consistent with the provider's New Hampshire 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 contracted providers to communicate openly with Well Sense members regarding all treatment options available to them including medication treatment regardless of benefit coverage limitations
- Inform members that Beacon does not offer any financial incentives to its contracted provider

community for limiting, denying, or not delivering medically necessary treatment to plan members
- Inform members that clinicians working at Beacon do not receive any financial incentives to limit or deny any medically necessary care

4.4. Non-Discrimination Policy and Regulations

In signing the PSA, providers agree to treat plan members without discrimination. Providers may not refuse to accept and treat a health plan member on the basis of their 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 a provider does not have the capability or capacity to provide appropriate services to a member, the provider needs to direct the member to call Beacon for assistance in locating needed services.

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

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

Beacon's goal is to ensure that all members receive behavioral healthcare that is accessible, respectful, and maintains the dignity of the member.

4.5. Confidentiality of Member Information

All providers are expected to comply with federal, state, and local laws regarding access to member information. With the enactment of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), members give consent for the release of information regarding treatment, payment, and healthcare operations at the sign-up for health insurance. Treatment, payment, and healthcare operations involve 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 a member in order to ensure compliance with contractual obligations
- Member information reviews in the context of management audits, financial audits, or program evaluations
- Chart reviews to monitor the provision of clinical services and ensure that authorization criteria are applied appropriately.

Member consent

At every intake and admission to treatment, the provider needs to explain the purpose and benefits of communication to the member's PCP and other relevant providers. The behavioral health clinician will request written consent from members to release information to coordinate care regarding mental health services or substance use disorder services or both, and primary care. A sample form is available here (See Provider Tools web page), or providers may use their own form; the form must allow the member to limit the scope of information communicated.

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

on the form. Providers must document all instances in which consent was not given, the reason why consent was not provided, and submit this report to Beacon no later than 60 calendar days following the end of the fiscal year.

Confidentiality of members' HIV-related information

Beacon works in collaboration with the Plan to provide comprehensive health services to members with health conditions that are serious, complex, and involve both medical and behavioral health factors. Beacon coordinates care with the health plan's medical and disease management programs and accepts referrals for behavioral health case management from the health plan. Information regarding HIV infection, treatment protocols and standards, qualifications of HIV/AIDS treatment specialists, and HIV/AIDS services and resources, medications, counseling and testing is available directly from the health plan.

Beacon will assist behavioral health providers or members interested in obtaining any of this information by referring them to the Plan's case management department. Beacon limits access to all health-related information, including HIV-related information and medical records, to staff trained in confidentiality and the proper management of patient information. Beacon's case management protocols require Beacon to provide any Plan member with assessment and referral to an appropriate treatment source. It is Beacon's policy to follow federal and state information laws and guidelines concerning the confidentiality of HIV-related information.

4.6. Well Sense Member Eligibility

Member identification cards

Well Sense members are issued one card, the plan membership card. The card is not dated, nor is it returned when a member becomes ineligible. Therefore, the presence of a card does not ensure that a person is currently enrolled or eligible with the Plan.

A Well Sense member card contains the following information:

- Member's name
- Plan name: Well Sense
- Plan identification number
- Member's date of birth
- Member Services Department: (855) 834-5655
- Routine or urgent medical care: Call your primary care physician (PCP)
- Emergency: Seek emergency room care right away or call 911
- Behavioral health services (mental health/substance use disorder): (855) 834-5655
- Well Sense Transportation to medical/behavioral health appointments: (844) 909-7433

Information for providers and billing offices

- For medical referral, prior authorization, hospital precertification, or to verify member eligibility, call (855) 834-5655.
- Pharmacies: Submit to EnvisionRx Options using the following data: BIN: 009893, PCN: ROIRX, RxGrp: WLSNS. For pharmacy questions, call (877) 957-1300.
- For behavioral health services, call (855) 834-5655.

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

Member eligibility changes occur frequently. Confirmation of eligibility process is the responsibility of the provider.

To facilitate reimbursement for services, providers are strongly advised to verify a Plan member's eligibility

upon admission to treatment and on each subsequent date of service.

The following resources are available to assist in eligibility verification:

Table 4-3: Member Eligibility Verification Tools

Online	Electronic Data Interchange (Edi)	Via Telephone
Beacon's eServices	Providers with EDI capability can use the 270/271 EDI transaction with Beacon. To set up an EDI connection, view the companion guide and then contact edi.operations@beaconhealthoptions.com	EDI Helpdesk (888) 247-9311

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

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

Please note: Member eligibility information on eServices is updated nightly. 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 are to check eligibility each visit.

4.7 Mental Health Parity

Federal and state laws require the plan to provide coverage for mental health and substance use disorder treatments as favorably as it provides coverage for other medical health services. This is referred to as parity. Parity laws require that coverage for mental health and/or substance use disorders be no more restrictive than coverage for other medical conditions, such as diabetes or heart disease. For example, if the plan provides unlimited coverage for physician visits for diabetes, it must do the same for depression or schizophrenia.

Parity means that:

- The plan must provide the same level of benefits for any mental health and/or substance use disorder as it would for other medical conditions a Member may have.
- The plan must not impose stricter prior authorization requirements and treatment limitations for mental health and substance use disorder benefits as it does for other medical benefits.
- The plan must provide Members and their providers with the medical necessity criteria used by the plan for prior authorization upon either the Member's request or provider's request.
- The plan must not impose aggregate lifetime or annual dollar limits on mental health or substance use disorder benefits.
- Within a reasonable time frame, the plan must provide the Member the reason for any denial of authorization for mental health and/or substance use disorder services.
- Within a reasonable timeframe, if the plan provides out-of-network coverage for other medical benefits, the plan must provide comparable out-of-network coverage for mental health and/or substance use disorder benefits.

The parity requirement applies to:

- Drug copayments
- Limitations on service coverage (such as limits on the number of covered outpatient visits)
- Use of care management tools (such as prescription drug rules and restrictions)
- Criteria for determining medical necessity and prior authorizations
- Prescription drug list structure, including copayments

If you think that the plan is not providing parity as explained above, you or the member have the right to file an appeal or file a grievance (complaint) with Well Sense Health Plan (877-957-1300).

If you think the plan did not cover behavioral health services (mental health and/or substance use disorder services) in the same way as medical services, you or the Member may also file a grievance or complaint with the New Hampshire Department of Insurance Consumer Services Hotline at 1-800-852-3416 (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8 a.m. to 4:30 p.m. ET, or online at nh.gov/insurance/consumers/complaints.htm.

Chapter 5

Quality Management and Improvement Program

5.1. Provider Role

5.2. Quality Monitoring

5.3. Treatment Records

5.4. Performance Standards and Measures

5.5. Practice Guidelines

5.6. Outcomes Measurement

5.7. Transitioning Members from One Behavioral Health Provider to Another

5.8. Reportable Incidents and Events

5.9. Fraud and Abuse

5.10. Federal False Claims Act

5.11. Grievances and Grievance Resolution

Table 5-1: QM&I 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) program whose goal is to continually monitor and improve the quality and effectiveness of behavioral health services delivered to members. Beacon's QM&I Program integrates the principles of continuous quality improvement (CQI) throughout our organization and the provider network.	▪ Continually evaluate the effectiveness of services delivered to health plan members ▪ Identify areas for targeted improvements ▪ Develop QI action plans to address improvement needs ▪ Continually monitor the effectiveness of changes implemented, over time	▪ Improve the healthcare status of members ▪ Enhance continuity and coordination among behavioral health care providers and between behavioral health and physical health 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

5.1. Provider Role

Beacon employs a collaborative model of continuous quality improvement (CQI), in which provider and member participation is actively sought and encouraged. In signing the PSA, all providers agree to cooperate with Beacon and the Plan QI initiatives. Beacon also requires each provider to have its own internal QM&I Program to continually assess quality of care, access to care, and compliance with medical necessity criteria. To participate in Beacon's Provider Advisory Council, email provider.relations@beaconhealthoptions.com. Members who wish to participate in the Member Advisory Council should contact the Member Services Department.

5.2. Quality Monitoring

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

- Site visits
- 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, and government and community agencies
  - Tracking of adverse incidents, grievances and appeals.
- Other quality improvement activities

On a regular 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 grievances or appeals pertaining to the provider, is maintained by the ombudsperson, and may be used by Beacon in profiling, recredentialing and network (re)procurement activities and decisions.

5.3. Treatment Records

Treatment record reviews

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

- Use of screening tools for diagnostic assessment of substance use disorders, adolescent depression, and ADHD
- Continuity and coordination with primary care providers and other treaters
- Explanation of member rights and responsibilities
- Inclusion of applicable required medical record elements as listed below
- Allergies and adverse reactions
- Medications
- Physical exam
- Scores from the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA)
- Instances where members did not grant consent to share information between PCPs and behavioral health providers

Beacon may conduct chart reviews onsite at a provider facility, or may ask a provider to copy and send specified sections of a member's medical record to Beacon. Any questions that a provider may have regarding Beacon's access to the plan member information should be directed to Beacon's privacy officer. Please contact us at (855) 834-5655 and ask to speak to the privacy officer.

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

Treatment record standards

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

Table 5-2: Treatment Documentation Standards

<table>
<tr><td>Member Identification Information</td><td>The treatment record contains the following member information:
Member name and health 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</td></tr>
<tr><td>Informed Member Consent for Treatment</td><td>The treatment record contains signed consents for the following:
Implementation of the proposed treatment plan
Any prescribed medications
Consent forms related to interagency communications
Individual consent forms for release of information to the member’s PCP and other behavioral health providers, if applicable; each release of information to a new party (other than Beacon or the Plan) requires its own signed consent form.
Consent to release information to the payer or MCO (In doing so, the provider is communicating to the member that treatment progress and attendance will be shared with the payer.)
For adolescents, ages 12–17, the treatment record contains consent to discuss behavioral health issues with their parents.
Signed document indicating review of patient’s rights and responsibilities
If a member does not consent to share information among PCPs and behavioral health providers:
All instances in which consent was not granted needs to be documented along with the reason for refusal, if possible and submitted to Beacon.</td></tr>
<tr><td>Medication Information</td><td>Treatment records contain medication logs clearly documenting the following:
All medications prescribed
Dosage of each medication
Dates of initial prescriptions
Information regarding allergies and adverse reactions are clearly noted
Lack of known allergies and sensitivities to substances are clearly noted.</td></tr>
<tr><td>Substance Use Disorder Information</td><td>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</td></tr>
<tr><td>Adolescent Depression Information</td><td>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?</td></tr>
</table>

<table>
<tr><td>ADHD Information</td><td>Documentation that members aged 6-12 were assessed for ADHD
Was family involved with treatment?
Is there evidence of the member receiving psychopharmacological treatment?</td></tr>
<tr><td>Diagnostic Information</td><td>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, including housing status and legal status.
A complete mental status evaluation is included in the treatment record, which documents the member’s:
Affect
Speech
Mood
Thought control, including memory
Judgment
Insight
Attention/concentration
Impulse control
Initial diagnostic evaluation and DSM diagnosis that is consistent with the stated presenting problems, history, mental status evaluation, and/or other relevant assessment information
Diagnoses updated at least quarterly basis</td></tr>
<tr><td>Treatment Planning</td><td>The treatment record contains clear documentation of the following:
Initial and updated treatment plans consistent with the member’s diagnoses, goals, and progress
Objective and measurable goals with clearly defined time frames for achieving goals or resolving the identified problems
Treatment interventions used and their consistency with stated treatment goals and objectives
Member, family and/or guardian’s involvement in treatment planning, treatment plan meetings and discharge planning
Copy of Outpatient Review Form(s) submitted, if applicable</td></tr>
<tr><td>SUD Treatment Planning</td><td>Clinical Evaluation shall be completed in accordance with SAMHSA Technical Assistance Publication (TAP) 21; Addiction Counseling Competencies and shall be completed prior to admission as part of interim services, or within 3 business days following admission.
For members being transferred from or otherwise referred by another provider, the provider shall use the clinical evaluation completed by the licensed behavioral health professional from the referring agency, which may be amended by the receiving facility.
Individualized treatment plan completed within 3 business days of the clinical evaluation that address all ASAM domains and justify LOC.
Individualized treatment goals, objectives, and interventions should be written in terms that are specific, measurable, attainable, realistic, and time relevant (SMART).
Treatment plan shall include member’s involvement in identifying,</td></tr>
</table>

	developing, and prioritizing goals, objectives, and interventions. ▪ Treatment plans shall be updated based on any changes in the ASAM domains and no less frequently than every 4 sessions or every 4 weeks, whichever is less frequent. ▪ Treatment plan updates should include documentation to the degree to which member is meeting goals and objectives, any modification to existing goals or addition of new goals, provider's assessment as to whether member needs to move to a different LOC based on ASAM continuing care, transfer, and discharge criteria, and should include the signature of the member and provider agreeing to treatment plan or documentation of member's refusal to sign to the treatment plan.
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 their strengths and limitations in achieving said goals and objectives ▪ Referrals to diversionary levels of care and services if the member requires increased interventions resulting from homicidality, suicidality, or the inability to function on a day-to-day basis ▪ Referrals and/or member participation in preventive and self-help services (e.g., stress management, relapse prevention, Alcoholics Anonymous, etc.) is included in the treatment record ▪ Member's response to medications and somatic therapies
Coordination and Continuity of Care	The treatment record contains clear documentation of the following: ▪ Documentation of communication and coordination between behavioral health providers, primary care physicians, ancillary providers, and health care facilities. (See Behavioral Health – PCP Communication Protocol later in this chapter, and download Behavioral Health – PCP Communication Form) ▪ Dates of follow-up appointments, discharge plans, and referrals to new providers
Additional Information for Outpatient Treatment Records	These elements are required for the outpatient medical record: ▪ Telephone intake/request for treatment ▪ Face-sheet ▪ Termination and/or transfer summary, if applicable ▪ The following clinician information on every entry (e.g., progress notes, treatment notes, treatment plan, and updates) should include the following treating clinician information: ○ Clinician's name ○ Professional degree ○ Licensure ○ NPI or Beacon identification number, if applicable ○ 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

5.4. Performance Standards and Measures

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

- Communication with PCPs and other providers treating shared members
- Availability of routine, urgent, and emergent appointments (See Chapter 2)
- Use of a trauma-informed care model for community mental health services, as defined by SAMHSA, with a thorough assessment of an individual's trauma history in the initial intake evaluation and subsequent evaluations to inform the development of an individualized service plan
- Behavioral health services shall be recovery and resiliency oriented based on SAMHSA's definition of recovery and resiliency.
- Community Mental Health Services shall be provided in accordance with the Medicaid State Plan and He-M 401.02 and He-M 426. This includes, but is not limited, to ensuring that the full range of Community Mental Health Services are appropriately provided to eligible members.
- The full continuum of SUD services shall be delivered in accordance to ASAM criteria and NH Code of Administration Rules, Chapter He-W 500, Part He-W 513.
- SUD providers shall ensure Peer Recovery Support is available to members as both a standalone service (regardless of an assessment), and as part of other treatment and Recovery services.
- Inpatient behavioral health providers, inclusive of SUD providers who provide 24-hour levels of care, shall ensure members are discharged with a discharge plan (i.e., an outpatient visit shall be scheduled before discharge to ensure access to proper provider/medication follow-up; and an appropriate placement or housing site shall be secured prior to discharge). Inpatient behavioral health providers, inclusive of SUD providers who provide 24-hour levels of care, shall ensure the final discharge instruction sheet is provided to the member and the member's authorized representative prior to discharge or the next business day for at least 98 percent of members discharged.
- Inpatient behavioral health providers, inclusive of SUD providers who provide 24-hour levels of care, shall ensure that the discharge progress note is provided to any treatment provider within seven calendar days of member discharged for at least 98 percent of members discharged.
- Providers are to notify Beacon of any member who is discharged Against Medical Advice (AMA) after an overdose.
- Inpatient behavioral health providers, inclusive of SUD providers who provide 24-hour levels of care, shall notify the member's local CMHC for any member being discharged to homeless and request that the member be connected with care management within 24 hours of discharge.

5.5. Practice Guidelines

Beacon and Well Sense 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. Beacon has posted links to these on our website. We strongly encourage providers to use these

guidelines and to consider these guidelines as a tool that may promote positive outcomes for clients. Beacon monitors provider utilization of guidelines through claim, pharmacy, and utilization data.

Beacon welcomes provider comments about the relevance and utility of the guidelines adopted by Beacon, any improved client outcomes 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 that Beacon adopted, please contact us at (855) 834-5655, option #2.

5.6. Outcomes Measurement

Beacon and the health plan strongly encourage and support providers in the use of outcomes measurement tools for all members. Outcomes data is used to identify potentially high-risk members who may need intensive behavioral health, medical, and/or social care management interventions.

Beacon and Well Sense receive aggregate data by provider, including demographic information and clinical and functional status, without member-specific clinical information.

Table 5-3: Communication between Behavioral Health Providers and Other Treaters

Communication Between Outpatient Behavioral Health Providers and PCPS, Other Treaters	Communication Between Inpatient/Diversionary Providers and PCPS, Other Outpatient Treaters
Outpatient behavioral health providers are expected to communicate with the member's PCP and other outpatient behavioral health providers if applicable, as follows: ▪ Notice of commencement of outpatient treatment within four visits or two weeks, whichever occurs first ▪ Updates at least quarterly during the course of treatment ▪ Notice of initiation and any subsequent modification of psychotropic medications ▪ Notice of treatment termination within two weeks Behavioral health providers may use Beacon's *Authorization for Behavioral Health Provider and PCP to Share Information Form* and the *Behavioral Health-PCP Communication Form* available for initial communication and subsequent updates, in Appendix B. Providers may also use their own form that includes the following information: ▪ Presenting problem/reason for admission ▪ Date of admission ▪ Admitting diagnosis ▪ Preliminary treatment plan ▪ Currently prescribed medications ▪ Proposed discharge plan ▪ Behavioral health provider contact name	With the member's informed consent, acute care facilities are expected to contact the PCP by phone and/or by fax, within 24 hours of a member's admission to treatment. Inpatient and diversionary providers must also alert the PCP 24 hours prior to a pending discharge, and must fax or mail the following member information to the PCP within three days post-discharge: ▪ Date of discharge ▪ Diagnosis ▪ Medications ▪ Discharge plan ▪ Aftercare services for each type, including: o Name of provider o Date of first appointment o Recommended frequency of appointments o Treatment plan Inpatient and diversionary providers must make every effort to provide the same notifications upon admission and discharge information to the member's outpatient therapist, if there is one. Acute care providers' communication requirements are addressed during continued stay and discharge reviews documented in Beacon's member record.

Communication Between Outpatient Behavioral Health Providers and PCPS, Other Treaters	Communication Between Inpatient/Diversionary Providers and PCPS, Other Outpatient Treaters
Request for PCP response by fax or mail within three business days of the request to include the following health information: ▪ Status of immunizations ▪ Date of last visit ▪ Dates and reasons for any and all hospitalizations ▪ Ongoing medical illness ▪ Current medications ▪ Adverse medication reactions, including sensitivity and allergies ▪ History of psychopharmacological trials Outpatient providers' compliance with communication standards is monitored through requests for authorization submitted by the provider, and through chart reviews.	

5.7. Communication between Behavioral Health Providers and Other Treaters

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. Transitional care may also be provided 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.

As part of care coordination activities, participating providers should identify all providers/participating providers involved in the medical and/or behavioral healthcare and treatment of a member. Subject to any required consent or authorization from the member, participating providers should coordinate the delivery of care to the member with these providers/participating providers, inclusive of coordination of treatment plans. Providers shall ensure members with physical health and behavioral health needs are appropriately and timely referred to their PCP for treatment of their physical health needs. All coordination, including PCP coordination, should be documented accordingly in the member treatment record. Beacon consent forms are available through the website.

Providers must comply with Beacon and state policies related to transition of care set forth by DHHS and included in the DHHS model Member Handbook.

5.8. Reportable Incidents and Events

Beacon requires that all providers report adverse incidents, other reportable incidents, and sentinel events involving Well Sense members to Beacon using the *NH DHHS Sentinel Event Reporting Form* available on Beacon's website (www.beaconhealthoptions.com/providers/dashboard/, select NH, Well Sense, and View Forms, Manuals, and FAQs). Providers shall ensure they follow DHHS's Sentinel Events policy when

reporting these events, in addition to Beacon's requirements.

Table 5-4: Reportable Incidents and Events – Overview

	Adverse Incidents	Sentinel Events	Other Reportable Incidents
Incident/ Event Description	An adverse incident is an occurrence that represents actual or potential serious harm to the well-being of a 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 member deaths ▪ Any absence without authorization (AWA) involving a member ▪ Any injury while in a 24-hour program that could, or did, result in transportation to an acute care hospital for medical treatment or hospitalization ▪ Any sexual assault or alleged sexual assault ▪ Any physical assault or alleged physical assault by a staff person or another patient against a member ▪ Any medication error or suicide attempt that requires medical attention beyond general first aid procedures ▪ Any unscheduled event that results in the evacuation of a program or facility (e.g., fire resulting in response by fire department)	▪ All medico-legal deaths: 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 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 day and may result in the need for finding alternative placement options for member	▪ Any non-medico-legal deaths ▪ Any AWA from a facility involving a member who does not meet the criteria for a sentinel event as described above ▪ Any physical assault or alleged physical assault by or against a member that does not meet the criteria of a sentinel event ▪ Any serious injury while in a 24-hour program requiring medical treatment, but not hospitalization; a serious injury is 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 are gathered in the aggregate and trended on a quarterly basis for the purpose of identifying opportunities for quality improvement.

	Adverse Incidents	Sentinel Events	Other Reportable Incidents
Reporting Method	▪ Beacon's Clinical Department is available 24 hours a day. ▪ Providers must call as soon as they become aware of an incident, regardless of the hour, to report such incidents. ▪ Providers should direct all such reports to their Beacon clinical manager or UR clinician by phone. ▪ In addition, providers are required to fax a copy of *the NH DHHS Sentinel Event Reporting Form* (for adverse and other reportable incidents and sentinel events) to Beacon's ombudsperson at (781) 994-7642. ▪ Incident and event reports should not be emailed unless the provider is using a secure messaging system.		
Provide the Following	Providers should be prepared to present: ▪ All relevant information related to the nature of the incident ▪ The parties involved (names and telephone numbers) ▪ The member's current condition ▪ Any improvement steps identified to maintain safety and prevent reoccurrence		

5.9. Fraud and Abuse

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

- **Fraud** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to them or some other person. It includes any act that constitutes fraud under applicable federal or state law.
- **Abuse** involves provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
- **Examples of provider fraud and abuse:** Altered medical records, patterns for billing which include billing for services not provided, up-coding, or bundling and unbundling or medically unnecessary care. This list is not inclusive of all examples of potential provider fraud.
- **Examples of member fraud and abuse:** Under/unreported income, household membership (spouse/absent parent), out-of-state residence, third party liability, or narcotic use/sales/distribution. This list is not inclusive of all examples of potential member fraud.

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

5.10. Federal False Claims Act

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

Summary of provisions

The FCA imposes civil liability on any person who knowingly:

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

Penalties

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

QUI TAM (whistleblower) provisions

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

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

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

Non-retaliation and anti-discrimination

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

Reduced penalties

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

If any member or provider becomes aware of any potential fraud by a member or provider, please contact us at (855) 834-5655 and ask to speak to the compliance officer or email Beacon at Compliance@beaconhealthoptions.com.

5.11. Grievances and Grievance Resolutions

A grievance is any expression of dissatisfaction by a member, member representative, or provider on a

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

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

Providers may register their own grievances and may register grievances on a member's behalf. Members, or their guardian or representative on the member's behalf, may also register grievances. Contact Beacon to register a grievance.

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

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

WellSense Medicare Advantage HMO Grievances
All WellSense Medicare Advantage HMO are reviewed and resolved by WellSense. The member grievance process begins upon WellSense's receipt of a verbal or written expression of dissatisfaction. Members can also file quality of care grievances with the QIO as well as WellSense.

The preferred way for a member or the member's Authorized Representative, including a provider on behalf of a member, to file a grievance is to put it in writing and send it to us by mail or fax. A grievance also may be submitted orally by calling the WellSense Member Services Department at (855) 833-8128 or TTY: 711.

Written grievances should include name, address, WellSense Medicare Advantage ID number, daytime telephone number, detailed description of the grievance (including relevant dates and provider names), and any applicable documents that relate to the grievance (such as billing statements). Written grievances should be faxed to WellSense at (617)-897-0805 or postal mailed to:

WellSense Medicare Advantage HMO
Member Grievances Department
529 Main Street, Suite 500
Charlestown, MA 02129

Members, or their Authorized Representatives, may also file a Grievance at any time with CMS.

In addition, whenever Beacon disapproves a member or an authorized representative's request for an expedited Organization Determination or extends the times for resolving an Organization Determination, members or their Authorized Representatives can file an expedited grievance. The also applies to WellSense disapproving a member or an authorized representative's request for an expedited appeal or extending the timeframe to resolve a standard appeal

WellSense resolves standard grievances within 30 calendar days and expedited grievances within 24 hours or as expeditiously as the member's condition warrants. It is the expectation of Well Sense that all providers kindly respond in a timely manner to requests for information relating to grievances.

Member and provider concerns about a denial of requested clinical service, adverse utilization management decision including adverse organization determinations, or an adverse action are not handled as grievances. See UM Reconsiderations and Appeals in Chapter 7, Utilization Management.

Chapter 6

Case Management and Utilization Management

6.1. Case Management

6.2. Utilization Management

6.3. Emergency Services

6.4. Return of Inadequate or Incomplete Treatment Request

6.5. Notice of Inpatient/Diversionary Approval or Denial

6.6. Decision and Notification Time Frames

6.1. Case Management

Beacon's Clinical Management program, a component of Beacon's person-centered Care Management (CM) program, is designed to ensure the coordination of care and integration of services among multiple providers and organizations. The primary goal of the program is stabilization and maintenance of members in their communities through the provision of community-based support services. These community-based providers can provide short-term services designed to respond with maximum flexibility to the needs of the individual member. The intensity and amount of support provided is customized to meet the individual needs of members and will vary according to the member's needs over time.

When clinical staff or providers identify members who demonstrate medical co-morbidity (e.g., pregnant women or diabetics), a high utilization of services, and an overall clinical profile that indicates that they are at high risk for admission or readmission into a 24-hour behavioral health or substance use disorder treatment setting, they may be referred to Beacon's CM program. The CM program utilizes care coordination as a short-term intervention for members with potential risk due to barriers in services, poor transitional care, and/or co-morbid medical issues that require brief targeted care management interventions. In addition to care coordination, the CM program includes liaisons with the Community Mental Health Centers who provide care designed for adults with severe and persistent mental illness and/or severe mental illness as well as children with serious emotional disturbance. CM is also available to dually diagnosed adults, pregnant women with behavioral health or substance use disorders, hospitalized children, and members with AIDS.

CM is a voluntary program. Member consent is required for participation. For further information on how to refer a member to case management services, please contact Beacon at (855) 834-5655.

As part of the Case Management program, providers agree to participate in a system-of-care model for members who are eligible for those services. That model includes attending system-of-care treatment team meetings and providing the services recommended by the system-of-care treatment team.

6.2. 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; case 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:

- UM decision-making is based only on appropriateness of care, service, and existence of coverage
- 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

Medical necessity

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

> Medically necessary services are provided by a licensed healthcare provider and provide services that (1) are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity or threaten some significant handicap; (2) for which there is no comparable medical service or site of service available or suitable for the member requesting the service that is more conservative and less costly; (3) are of a quality that meets generally accepted standards of healthcare; and (4) that are reasonably expected to benefit the person. This definition applies to all levels of care and all instances of Beacon's utilization

review.

Level of care criteria

Beacon's level of care criteria (LOCC) are the basis for all medical necessity determinations. Beacon's LOCC, specific for the plan for each level of care, is accessible through eServices. Providers and members may also Contact Us to request a printed copy of Beacon's LOCC at no cost.

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), American Academy of Child and Adolescent Psychiatry (AACAP), Substance Abuse and Mental Health Services Administration (SAMHSA); and the American Society of Addiction Medicine (ASAM). Beacon's LOCC are reviewed and updated annually or more often as needed by the Level-of-Care Committee (which contains physicians and licensed clinicians) to incorporate new treatment applications and technologies that are adopted as generally accepted professional medical practice. New treatment applications and technologies may be presented to the Provider Advisory Council for review and recommendations.

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

Utilization management terms and definitions

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

Table 6-1: UM Terms and Definitions

Term	Definition
Adverse Determination	A decision to deny, terminate, or modify (an approval of fewer days, units or another level of care other than was requested, which the practitioner does not agree with) an admission, continued inpatient stay, or the availability of any other behavioral healthcare service, for: a. Failure to meet the requirements for coverage based on medical necessity b. Appropriateness of healthcare setting and level-of-care effectiveness c. 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

TERM	DEFINITION
	5. Beacon's failure to act within the time frames for making authorization decisions 6. Beacon's failure to act within the time frames for making appeal decisions
Non-Urgent Concurrent Review 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 a 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; or ▪ In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that could not be adequately managed without the care or treatment that is requested.
Urgent Concurrent Review Decision	Any review for a requested extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments in an acute treatment setting, when a member's condition meets the definition of urgent care, above
Urgent Pre-Service Decision	Formerly known as a pre-certification decision, any case or service that must be approved before a member obtains care or services in an inpatient setting, for a member whose condition meets the definition of urgent care above. An urgent pre-service decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment in an acute treatment setting.

Authorization procedures and requirements

This section describes the processes for obtaining authorization for inpatient, diversionary, and outpatient levels of care. This section also describes the process 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.

Member eligibility verification

The first step in seeking authorization is to determine the member's eligibility. Since member eligibility changes occur frequently, providers are advised to verify a plan member's eligibility upon admission to, or initiation of, treatment as well as on each subsequent day or date of service to facilitate reimbursement for services. Instructions for verifying member eligibility are presented in Chapter 3.

Member eligibility can change, and possession of a 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 (855) 834-5655.

6.3. 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 medical condition follows:

> "…a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person."

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. An after-hours assessment usually takes place at an emergency department of a local hospital. A master's-level clinician, in conjunction with a psychiatrist if necessary, completes the assessment. An assessment may determine the need for an emergency outpatient appointment, immediate care in a hospital or another community residential alternative.
After the emergency evaluation is completed, and if admission to a level of care that requires a notice of admission is needed, the emergency services clinician must call Beacon to complete a clinical review.
The emergency services clinician is responsible for locating a psychiatric bed, but may request Beacon's assistance in this process. Beacon may contact an out-of-network facility in cases where there is not a timely or appropriate placement available within the network. In cases where there is no in-network or out-of-network psychiatric facility available, Beacon will authorize boarding the member on a medical unit until an appropriate placement resource becomes available.

Emergency Services teams shall employ clinicians and certified peer support specialists to be available to members as needed.

Beacon clinician availability

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

Disagreement between Beacon and attending emergency service physician

For acute services, in the event that Beacon's physician advisor 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. Treatment shall be considered appropriate 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.

Table 6-2: Authorization Procedures and Requirements

<table>
<tr><th></th><th>Inpatient and Diversionary Services</th><th>Outpatient Services</th></tr>
<tr><td>Initial Assessment</td><td>Beacon requires an evaluation for all members who require admission to acute services. To the maximum extent feasible, all members must be screened by an emergency service clinician at the nearest emergency room prior to admission to:
▪ Inpatient mental health
▪ Diversionary services</td><td>Prior authorization is not required for the first 24 sessions for children and 18 sessions for adults.

Psychological testing and outpatient ECT require prior authorization. Providers must submit a claim in accordance with Beacon's billing policies and procedures.</td></tr>
<tr><td>Pre-Service</td><td colspan="2">See Table 5-3: Information Due at Time of Review</td></tr>
<tr><td>Services Requiring Authorization</td><td colspan="2">▪ Mental Health Diversionary services
▪ Psychological and neuropsychological testing
▪ Outpatient and Inpatient Electroconvulsive Therapy (ECT)
▪ Outpatient Transcranial Magnetic Stimulation (TMS)
▪ Applied Behavior Analysis (ABA) Services

1. Emergency services do not require pre-service authorization; however, facilities must notify Beacon with a Notice of Admission of the emergency treatment and/or admission within 24 hours.
2. Out-of-network service is not a covered benefit. It may be authorized in some circumstances where needed care is not available within the network.
3. Providers must request approval from Beacon prior to transferring members. The member must meet Beacon's admission criteria for the receiving facility prior to transfer. Without pre-service authorization for the receiving facility, elapsed days will not be reimbursed or considered for appeal.</td></tr>
<tr><td>Other Services Requiring Pre-Service Approval</td><td colspan="2">Inpatient services is not a covered benefit with out-of-network providers. Note that out-of-network care benefit, but may be approved in certain circumstances.</td></tr>
<tr><td>Exceptions from Authorization</td><td colspan="2">Group therapy, medication management and methadone maintenance do not require authorization.</td></tr>
<tr><td>Concurrent Review</td><td colspan="2">See Table 5-3: Information Due at Time of Review</td></tr>
<tr><td>Extended Stay Authorization</td><td colspan="2">Continuation beyond the previously authorized length of stay requires review and approval by Beacon prior to expiration of the existing authorization.</td></tr>
<tr><td>Notice of Authorization Determination</td><td colspan="2">Members must be notified of all pre-service and concurrent denial decisions. Members are notified by mail of all acute pre-service and concurrent denial decisions within one business day.

The denial notification letter sent to the member or member's guardian, practitioner,</td></tr>
</table>

	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.

Table 6-3: UM Review Requirements – Mental Health Inpatient and Acute Diversionary

Pre-Service Review	Continued Stay (Concurrent) Review	Post-Service Review
The facility clinician making the request must have 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 V or appropriate ICD 10 diagnosis ▪ Description of precipitating event and current symptoms requiring inpatient psychiatric care ▪ Medication history ▪ Substance use history ▪ Prior hospitalizations and psychiatric treatment ▪ Member's and family's general medical and social history ▪ Recommended treatment plan relating to admitting symptoms and the member's anticipated response to treatment	To conduct a continued stay review, call a Beacon UR clinician with the following required information: ▪ Member's current diagnosis and treatment plan, including physician's orders, special procedures, and medications ▪ Description of the member's response to treatment since the last concurrent review ▪ Member's current mental status, discharge plan, and discharge criteria, including actions taken to implement the discharge plan ▪ Report of any medical care beyond routine is required for coordination of benefits with health plan (routine medical care is included in the per diem rate).	Post-service reviews may be conducted for inpatient, diversionary or outpatient services rendered when necessary. To initiate a post-service review, 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 advisor completes a clinical review of all available information, in order to render a decision.

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

For Substance Use Disorder Inpatient Programs and Acute Divisionary Services:

- Clinicians must be trained in the use of ASAM and apply ASAM criteria when determining the appropriate level of care for Substance Use Disorder Inpatient and Acute Divisionary Services
- No prior authorization is required. Providers should submit a Notice of Admission (NOA) through

eServices for all substance use disorder inpatient and acute divisionary levels of care.

6.4. Return of Inadequate or Incomplete Treatment Requests

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

6.5. Notice of Inpatient/Diversionary Approval or Denial

Verbal notification of approval is provided at the time of pre-service or a continuing stay review. For an admission, the evaluator then locates a bed in a network facility and communicates Beacon's approval to the admitting unit. Notice of admission, or continued stay approval, is mailed to the member or member's guardian, and the requesting facility within the 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. All denial decisions are made by a Beacon physician or psychologist advisor. The UR clinician and/or Beacon physician advisor offers the treating provider the opportunity to seek reconsideration.

All member notifications include instructions on how to access interpreter services, how to proceed if the notice requires translation or a copy in an alternate format, and toll-free telephone numbers for TDD/TTY capability, in established prevalent languages (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 level-of-care criteria documented in Chapters 8 -12 (accessible through eServices) to determine whether the service meets medical necessity for continuing outpatient care.

6.6. Decision and Notification Time Frames

Beacon is required by the state, federal government, and NCQA to render utilization review decisions in a timely manner to accommodate the clinical urgency of a situation. Beacon has adopted the strictest time frame for all UM decisions in order to comply with the various requirements.

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

Table 6-4: Decision and Notification Time Frames

	Type Of Decision	Decision Time Frame	Verbal Notification	Written Notification
Pre-Service Review				
Initial Authorization for Inpatient Behavioral Health Emergencies	Expedited	Within 30 minutes	Within 30 minutes	Within 24 hours
Initial Authorization for Non- emergent Inpatient Behavioral Health Services	Expedited	Within 2 hours	Within 2 hours	Within 24 hours
Initial Authorization for Other Urgent Behavioral Health Services	Urgent	Within 72 hours	Within 72 hours	Within 72 hours
Initial Authorization for Non- Urgent Behavioral Health Services	Standard	Within 14 calendar days	Within 1 business day	Within 14 calendar days
Concurrent Review				
Continued Authorization for Inpatient and Other Urgent Behavioral Health Services	Urgent/ Expedited	Within 24 hours	Within 24 hours	Within 24 hours
Continued Authorization for Non-urgent Behavioral Health Services	Non-Urgent/ Standard	Within 14 calendar days	Within 1 business day	Within 14 calendar days
Post-Service				
Authorization for Behavioral Health Services Already Rendered	Non-Urgent/ Standard	Within 30 calendar days	1 business day from day of decision	Within 30 calendar days

If information is needed, Well Sense must notify the member/provider within 24 hours of the information needed and make a decision no later than 48 hours after the receipt of the additional information or the end of the period given for additional information (total of 72 hours from receipt of request).

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

For an adverse standard authorization decision, Beacon shall provide written notification to the provider and member within 3 calendar days of the decision.

Chapter 7

Clinical Reconsideration and Appeals

7.1. Request for Reconsideration of Adverse Determination

7.2. Clinical Appeal Process

7.3. Administrative Appeal Process

7.1. Request for Reconsideration of Adverse Determination

Well Sense Medicaid:
If a plan member, or member's provider, disagrees with a utilization review decision issued by Beacon, the member, their authorized representative, or the provider may request reconsideration. Please call Beacon promptly upon receiving notice of the denial for which reconsideration is requested.

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

WellSense Medicare Advantage HMO
If a plan member, or member's provider, disagrees with an organization determination issued by Beacon, the member, their authorized representative, or the provider must request a member appeal through WellSense Medicare Advantage HMO.

7.2. Clinical Appeal Process

WellSense Medicare Advantage HMO Overview
Member appeals for WellSense Medicare Advantage HMO are not delegated to Beacon. Follow the instructions below to file a member appeal on behalf of a member with WellSense Medicare Advantage HMO.

Member appeals must be filed with WellSense Medicare Advantage HMO within 60 calendar days of the date of the adverse organization determination from Beacon. The WellSense Medicare Advantage HMO internal appeals process is inclusive of one level of review for both standard and expedited appeals.

The preferred way for a member or the member's Authorized Representative, including a provider on behalf of a member, to file a member appeal is to put it in writing and send it to WellSense Medicare Advantage HMO by mail or fax. A member appeal may also be filed orally by calling the WellSense Medicare Advantage HMO Member Services Department at 855-833-8128.

Written member appeals should include name, address, WellSense Medicare Advantage HMO ID number, day time telephone number, detailed description of the appeal, and any applicable documents and clinical information that relate to the member appeal. Written member appeals should be faxed to 617-897-0805 or postal mailed to:

WellSense Medicare Advantage HMO
Member Appeals Department
529 Main Street, Suite 500
Charlestown, MA 02129

WellSense Medicare Advantage HMO resolves standard member appeals as expeditiously as the member's condition warrants, but no later than 30 calendar days from receipt of request. The Plan will resolve all expedited member appeals within 72 hours from receipt of request.

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

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

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

Peer review

A peer review conversation may be requested at any time by the treating provider and may occur prior to or after an adverse determination, or upon request for a reconsideration. Beacon UR clinicians and physician advisors are available daily to discuss denial cases by phone at (855) 834-5655.

Urgency of appeal processing

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

Designation of authorized member representative (AMR)

If the member is designating an appeal representative to appeal on their behalf, the member must complete and return a signed and dated *Designation of Appeal Representative Form* prior to Beacon's deadline for resolving the appeal. Failure to do so will result in dismissal of the appeal. In cases where the appeal is expedited, a provider may initiate appeal without written consent from the member.

Appeal process detail

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

- Table 1: Expedited Clinical Appeals
- Table 2: Standard Clinical Appeals Each table illustrates:
  - How to initiate an appeal
  - Authorized Member Representative (AMR) requirements
  - Resolution and notification time frames for expedited and standard clinical appeals, at the first and external review levels

Table 7-1: Expedited Clinical Appeals

Level 1 Appeal	Level 2 Appeal	External Review
Members, their legal guardian, or their authorized representative have up to 60 calendar days after receiving notice of an action in which to file an appeal. If the member designates an authorized representative to act on their behalf, Beacon will attempt to obtain a signed and dated *Authorization of Representative Form* (F-10126). All expedited internal appeals requested by a member's provider will be processed by Beacon even if Beacon has not received the Authorization of Representative Form. Both verbal and written communication can take place with a provider who initiated the expedited appeal or with the individual who the member verbally designated as their representative. A Beacon physician advisor, who has not been involved in the initial decision, reviews all available information and attempts to speak with the member's attending physician. A decision is made within 72 hours of initial request. Throughout the course of an appeal, the member shall continue to receive services without liability for services previously authorized by Beacon, until he/she is notified of the expedited appeal determination. In order for services to continue without liability, the expedited appeal request must be submitted within 10 calendar days of the action.	N/A	

Level 1 Appeal	Level 2 Appeal	External Review
Contact Information: Internal expedited appeal requests can be made by calling Beacon's appeals coordinator at (844) 231-7949 (after hours please call: (855) 834-5655).	N/A	**Contact Information:** Requests for a fair hearing with the state can be made in writing. Written requests for an appeal must be submitted no later than 120 calendar days after the date of the internal expedited appeal determination to: Administrative Appeals Unit NH Department of Health and Human Services 105 Please Street, Room 121C Concord, NH 03301 FAX 603-271-8422 The fair hearing request must be submitted within 10 calendar days from the date of Beacon's notice regarding your first level of appeal in order to continue receiving the requested services.

* ***Please note that providers may act as an Authorized Member Representative.***

Table 7-2: Standard Clinical Appeals

Level 1 Appeal	Level 2 Appeal	External Review

Members, their legal guardian, or their authorized representative have up to 60 calendar days after receiving notice of an action in which to file an appeal. If the member designates an authorized representative to act on their behalf, the member must complete and return a signed and dated *Authorization of Representative Form* (F-10126) prior to the deadline for resolving the appeal (30 calendar days). Failure to do so prior to the appeal due date will result in dismissal of the appeal. However, verbal and written communication can only occur with the member or their legal guardian until such time as the form is received. Both verbal and written communication can take place with a provider who initiated the appeal or with the individual whom the member verbally designated as their representative.	N/A	

Level 1 Appeal	Level 2 Appeal	External Review
A Beacon physician advisor, who has not been involved in the initial decision, reviews all available information. If the appeal requires review of medical records (post-service situations), the member or authorized member representative's signature is required on an Authorization to Release Medical Information Form authorizing the release of medical and treatment information relevant to the appeal. If the medical record with the Authorization to Release Medical Information Form is not received prior to the deadline for resolving the appeal, a resolution will be rendered based on the information available. Throughout the course of an appeal, the member may continue to receive services without liability for services previously authorized by Beacon, until they are notified of the appeal determination. The member may be held liable for payment of continuing services if the appeal is not deemed in his/her favor. The provider must submit the medical chart for review. If the chart is not received within 20 days of the initial letter, a reminder letter is sent, giving an additional 15 days. If the chart is not received, a decision is made, based on the available information. A decision is made within 30 calendar days of the appeal request.		

Level 1 Appeal	Level 2 Appeal	External Review
Contact Information: Internal appeal requests can be made by calling Beacon's appeals coordinator at (844) 231-7949 (after hours please call: (855) 834-5655) or in writing to: Appeals Coordinator Beacon Health Options P.O. Box 1856 Hicksville, NY 11802	N/A	**Contact Information:** Requests for a fair hearing with the state can be made in writing. Written requests for an appeal must be submitted no later than 120 calendar days after the date of the appeal determination to: Administrative Appeals Unit NH Department of Health and Human Services 105 Please Street, Room 121C Concord, NH 03301 FAX 603-271-8422 The fair hearing request must be submitted within 10 calendar days from the date of Beacon's notice regarding your first level of appeal in order to continue receiving the requested services.

**Please note that providers may act as an Authorized Member Representative.*

DHHS SHIP Program

The State Health Insurance Assistance Program, or SHIP, is a federal grant program that helps states enhance and support a network of local programs, staff, and volunteers. Through one-on-one personalized counseling, education, and outreach, this network of resources provides accurate and objective information and assistance to Medicare beneficiaries and their families. These resources allow the recipients to better understand and use their Medicare benefits.

If Well Sense determines that a dual-eligible member's appeal is solely related to a Medicare service, the Plan shall refer the member and/or authorized representative to New Hampshire's SHIP program, which is currently administered by ServiceLink Aging and Disability Resource Center. Members and/or authorized representatives will be informed that they may contact the SHIP program toll free at (866) 634-9412 or by accessing its website at www.servicelink.org. Members and/or authorized representatives may also send appeals to:

New Hampshire Department of Health and Human Services
Bureau of Elderly and Adult Services
129 Pleasant Street
Governor Hugh Gallen State Office Park
Concord, NH 03301-3857

7.3. Provider Appeal Process

Beacon shall provide written notice to the provider of any adverse action and include in its notice a description of the basis of the adverse action and the right to appeal the adverse action. Providers shall submit a written request for an appeal to Beacon, together with any evidence or supportive documentation it wishes Beacon to

consider, within 30 calendar days of:

1. The date of Beacon's written notice of advising the provider of the adverse action to be taken; or
2. The date on which Beacon should have taken a required action and failed to take such action. Beacon may extend the decision deadline by an additional 30 calendar days to allow the provider to submit evidence or supportive documentation, and for other good cause determined by Beacon.

Beacon shall ensure that all Provider Appeal decisions are determined by an administrative or clinical professional with expertise in the subject matter of the Provider Appeal. Beacon may offer a reconsideration with a peer-to-peer review, with a like clinician or doctor, upon request, for providers who receive an adverse decision from Beacon. Any such reconsideration request should occur in a timely manager and before the provider seeks recourse through the Provider Appeal or state fair hearing process.

Beacon will maintain a log and records of all Provider Appeals, including for all matters handled by delegated entities, for a period not less than 10 years. At a minimum, log records shall include:

1. General description of each appeal;
2. Name of the provider;
3. Date(s) of receipt of the appeal and supporting documentation, decision, and effectuation, as applicable; and
4. Name(s), title(s), and credentials of the reviewer(s) determining the appeal decision.

If Beacon fails to adhere to notice and timing requirements, then the provider is deemed to have exhausted Beacon's Appeals Process and may initiate a state fair hearing.

Beacon shall provide written notice of resolution of the Provider Appeal (Resolution Notice) within 30 calendar days from either the date Beacon receives the appeal request, or if an extension is granted to the provider to submit additional evidence, the date on which the providers evidence is received by Beacon.

The Resolution Notice shall include:

1. Beacon's decision;
2. The reason for Beacon's decision;
3. The provider's right to request a state fair hearing; and
4. For overturned appeals, Beacon shall take all steps to reverse the adverse action within 10 calendar days.

The provider must exhaust Beacon's Provider Appeals Process before pursuing a state fair hearing. Beacon is bound by the state fair hearing determination.

Chapter 8

Billing Transactions

8.1. General Claim Policies

8.2. Coding

8.3. Coordination of Benefits

8.4. Provider Education and Outreach

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.

8.1. General Claims Policies

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

Definition of "clean claim"
A clean claim is defined as one that has no defect and is complete, including required, substantiating documentation of particular circumstance(s) warranting special treatment without which timely payments on the claim would not be possible.

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

Provider responsibility
The individual provider is ultimately responsible for accuracy and valid reporting of all claims submitted for payment. A provider using the services of a billing agency must ensure through legal contract (a copy of which must be made available to Beacon upon request) that the responsibility of a billing service to report claim information as directed by the provider is 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 co-payments when appropriate. See Chapter 3, Prohibition on Billing Members, for more information.

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

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

Claim turnaround time
All clean claims will be adjudicated within 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 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.

8.2. Coding

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

- Providers are required to submit HIPAA-compliant coding on all claim submissions; this includes HIPAA-compliant revenue, CPT, HCPCS and ICD-10 codes. Providers may refer to their Exhibit A for a complete listing of contracted, reimbursable procedure codes.
- Beacon accepts only ICD-10 diagnosis codes as listed and approved by CMS and HIPAA. In order to be considered for payment by Beacon, all claims must have a Primary ICD-10 diagnosis in the range of F01-F99. 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. The table below lists HIPAA-compliant discharge status codes.

Table 8-1: Discharge Status Codes

Code	Description
01	Discharged to Home/Self-Care
02	Discharged/Transferred to Another Acute Hospital
03	Discharged/Transferred to Skilled Nursing Facility
04	Discharged/Transferred to Intermediate Care Facility
05	Discharged/Transferred to Another Facility
06	Discharged/Transferred to Home/Home Health Agency
07	Left Against Medical Advice or Discontinued Care
08	Discharged/Transferred Home/IV Therapy
09	Admitted as Inpatient to this Hospital
20	Expired
30	Still a Patient

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

Table 8-2: Bill Type Codes

Type of Facility - 1st Digit	Bill Classification - 2nd Digit	Frequency - 3rd Digit
1. Hospital	1. Inpatient	1. Admission through Discharge Claim
1. Skilled Nursing Facility	. Inpatient Professional Component	2. Interim – First Claim
2. Home Health	3. Outpatient	3. Interim – Continuing Claims
3. Christian Science Hospital	4. Diagnostic Services	4. Interim – Last Claim
Christian Science Extended Care Facility	5. Intermediate Care – Level I	5. Late Charge Only
6. Intermediate Care Facility	6. Intermediate Care – Level II	6-8. Not Valid

Modifiers

Modifiers may 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 7-3 lists HIPAA-compliant modifiers accepted by Beacon. Please see your Exhibit A for Modifiers for which you are contracted.

Table 8-3: Modifiers

HIPAA Modifier	Modifier Description	HIPAA Modifier	Modifier Description
AB	Psychiatrist (This modifier required when billing for 90862 provided by a psychiatrist.)	HL	Intern
AH	Clinical psychologist	HM	Less than bachelor's-degree level
AJ	Clinical social worker	HN	Bachelor's-degree level
HA	Child/adolescent program	HO	Master's-degree level
HB	Adult program, non-geriatric	HP	Doctoral level
HC	Adult program, geriatric	HQ	Group setting
HD	Pregnant/parenting women's program	HR	Family/couple with client present
HE	Behavioral health program	HS	Family/couple without client present
HF	Substance use program	HT	Multi-disciplinary team
HG	Opioid addiction treatment program	HU	Funded by child welfare agency
HH	Integrated behavioral health/substance use disorder program	HW	Funded by state behavioral health agency

HIPAA Modifier	Modifier Description	HIPAA Modifier	Modifier Description
HI	Integrated behavioral health and mental retardation/developmental disabilities program	HY	Funded by juvenile justice agency
HU	Employee assistance program	SA	Nurse practitioner (this modifier required when billing 90862 performed by a nurse practitioner)
HK	Specialized behavioral health programs for high-risk populations	SE	State and/or federally funded programs/services
TD	Registered nurse	U1	Serious and persistent mental illness (SPMI)
TF	Intermediate level of care	U2	Serious mental illness (SMI)
TG	Complex/high level of care	U3	Psychology intern
TH	Obstetrics	U4	Social work intern
TJ	Program group, child, and/or adolescent	U5	SMI low utilizer
TR	School-based individualized education program (IEP) services provided outside the public school district responsible for the student	U6	Serious emotional disability (SED)
UK	Service provided on behalf of the client to someone other than the client-collateral relationship	U7	Serious emotional disability (SED) with interagency involvement

Time limits for filing claims

Beacon must receive claims for covered services within the designated filing limit:

- Within 120 days of the dates of service on outpatient claims
- Within 120 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 120-day filing limit will deny unless submitted as a waiver or reconsideration request, as described in this chapter.

8.3. Coordination of Benefits (COB)

In accordance with The National Association of Insurance Commissioners (NAIC) regulations, Beacon coordinates benefits for behavioral health and substance use disorder 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 (EOB) report and received by Beacon within 120 days of the date on the primary insurance EOB.
- Beacon reserves the right of recovery for claims in which a primary payment was made for dates of service that are within 180 days of receipt of COB information that deems Beacon the secondary payer. Beacon applies all Medicare recoupments and adjustments to future claims processed, and reports such

recoupments and adjustments on the EOB.
- Providers should use the *TPL Indicator Form* to notify Beacon of the potential existence of other health insurance coverage and to include a copy of the enrollee's health insurance card with the TPL Indicator Form whenever possible.

8.4. Provider Education and Outreach

Summary
In an effort to help providers that may be experiencing claims payment issues, Beacon conducts 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 may be having an adverse financial impact and to 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 a 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, further assistance, or to request training.

Claim inquiries and resources
Additional information is available through the following resources:

Online
- Chapter 3 of this Manual
- Beacon's Claims Page
- Read About eServices
- eServices User Manual
- Read About EDI
- EDI Transactions - 837 Companion Guide
- EDI Transactions - 835 Companion Guide
- EDI Transactions - 270-271 Companion Guide

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

Telephone

EDI:	(888) 247-9311
TTY:	711
Claims:	(855) 834-5655
Members:	(855) 834-5655

Electronic media options
Providers are expected to complete claims transactions electronically through one of the following, where applicable:
- **Electronic Data Interchange (EDI)** supports electronic submission of claim batches in HIPAA-compliant 837P format for professional services and 837I format for institutional services. Providers

may submit claims using EDI/837 format directly to Beacon or through a billing intermediary. If using Emdeon as the billing intermediary, two identification numbers must be included in the 837 file for adjudication:
  - Beacon's payor ID is 43324.
  - Beacon's health plan-specific ID is 032.
- **eServices** enables providers to submit inpatient and outpatient claims without completing a CMS 1500 or UB04 claim form. Because much of the required information is available in Beacon's database, most claim submissions take less than one minute and contain few, if any errors.

Claim transaction overview

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

Table 8-4: Claim Transaction Overview

Transaction	Access On:		Applicable When?	Timeframe For Receipt By Beacon	Other Information
	EDI	eServices			
Member Eligibility Verification	Y	Y	▪ Completing any claim transaction ▪ Submitting clinical authorization requests	N/A	N/A
Submit Standard Claim	Y	Y	▪ Submitting a claim for authorized, covered services, within the timely filing limit	Within 120 days after the date of service	N/A
Resubmission of Denied Claim	Y	Y	▪ Previous claim was denied for any reason except timely filing	Within 90 days after the date on the EOB	▪ Claims denied for late filing may be resubmitted as reconsiderations ▪ Rec ID is required to indicate that claim is a resubmission.

Transaction	Access On:		Applicable When?	Timeframe For Receipt By Beacon	Other Information
	EDI	eServices			
120-Day Waiver* (Request for waiver of timely filing limit)	N	N	A claim being submitted for the first time will be received by Beacon after the original 120-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 plan retroactively ▪ Third-party coverage is available and was billed first. (A copy of the other insurance's explanation of benefits or payment is required.)	Within 120 days from the qualifying event	▪ Third-party coverage is available and was billed first. (A copy of the other insurance's explanation of benefits or payment is required.) ▪ A claim submitted beyond the filing limit that does not meet the above criteria may be submitted as reconsideration request. ▪ Beacon's waiver determination is reflected on a future EOB with a message of "Waiver Approved" or "Waiver Denied": If waiver of the filing limit is approved, the claim appears adjudicated; if the request is denied, the denial reason appears.
Request for Reconsideration of Timely Filing Limit*	N	Y	▪ Claim falls outside of all time frames and requirements for resubmission, waiver and adjustment	Within 60 days from the date of payment or nonpayment	▪ Future EOB shows "Reconsideration Approved" or "Reconsideration Denied" with denial reason
Request to Void Payment	N	N	▪ Claim was paid to provider in error ▪ Provider needs to return the entire paid amount to Beacon	N/A	***Do NOT send refund check to Beacon.***

Transaction	Access On:		Applicable When?	Timeframe For Receipt By Beacon	Other Information
	EDI	eServices			
Request for Adjustment	Y	Y	▪ The amount paid to the provider on a claim was incorrect. ▪ Adjustment may be requested to correct: 1. Underpayment (positive request) 2. Overpayment (negative request)	▪ Positive request must be received by Beacon within 90 days from the date. of original payment ▪ No filing limit applies to negative requests.	▪ ***Do NOT send a refund check to Beacon.*** ▪ ***A Rec ID is required to indicate that the claim is an adjustment.*** ▪ Adjustments are reflected on a future EOB as recoupment of the previous (incorrect) amount, and if money is owed to the 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	▪ Available 24/7 for all claim transactions submitted by providers	N/A	▪ ***Claim status is posted within 48 hours after receipt by Beacon.***

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

Paper 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 require less time and have a higher rate of approval since most

errors are eliminated.

For paper submissions, providers are required to submit clean claims on the National Standard Format CMS1500 or UB04 claim form. No other forms are accepted.

Mail paper claims to:
Beacon Health Options
Well Sense Claims Department
P. O. Box 1866
Hicksville, NY 11802-1866

Beacon does not accept claims transmitted by fax.

Professional Services: Instructions for Completing the CMS 1500 Form

Beacon Discourages Paper Transactions

Before submitting paper claims, please review electronic options earlier in this chapter.

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

The following table lists each numbered block on the CMS 1500 form with a description of the requested information, and indicates which fields are required in order for a claim to process and pay.

Table 8-5: CMS 1500 Form

Table Block #	Required?	Description
1	No	Check Applicable Program
1a	Yes	Member's Plan ID Number
2	Yes	Member's Name
3	Yes	Member's Birth Date and Sex
4	Yes	Insured's Name
5	Yes	Member's Address
6	No	Member's Relationship to Insured
7	No	Insured's Address
8	Yes	Member's Status
9	Yes	Other Insured's Name (if applicable)
9a	Yes	Other Insured's Policy or Group Number
9b	Yes	Other Insured's Date of Birth and Sex
9c	Yes	Employer's Name or School Name
9d	Yes	Insurance Plan Name or Program Name
10a-c	Yes	Member's Condition Related to Employment
11	No	Member's Policy, Group, or FICA Number (if applicable)
11a	No	Member's Date of Birth (MM, DD, YY) and Sex (check box)
11b	No	Employer's Name or School Name (if applicable)
11c	No	Insurance Plan Name or Program Name (if applicable)
11d	No	Is there another health benefit plan?
12	Yes	Member's or Authorized Person's Signature and Date on File

Table Block #	Required?	Description
13	No	Member's or Authorized Person's Signature
14	No	Date of Current Illness
15	No	Date of Same or Similar Illness
16	No	Date Client Unable to Work in Current Occupation
17	No	Name of Referring Physician or Other Source (if applicable)
17B	No	NPI of Referring Physician
18	No	Hospitalization dates Related to Current Services (if applicable)
19	Yes	Additional Claim Information (Designated by NUCC), if applicable. (Record ID if applicable)
20	No	Outside Lab?
21	Yes	Diagnosis or Nature of Illness or Injury.
22	No	Medicaid Resubmission Code or Former Control Number
23	Yes	Prior Authorization Number (if applicable)
24a	Yes	Date of Service
24b	Yes	Place of Service Code (HIPAA-compliant)
24d	Yes	Procedure Code (HIPAA-compliant between 290 and 319) and Modifier, when applicable
24e	Yes	Diagnosis Code – 1, 2, 3, or 4
24f	Yes	Charges
24g	Yes	Days or Units
24h	No	EPSDT
24i	No	ID Qualifier
24j	Yes	Rendering Provider Name and Rendering Provider NPI
25	Yes	Federal Tax ID Number
26	No	Provider's Member Account Number
27	No	Accept Assignment (check box)
28	Yes	Total Charges
29	Yes	Amount Paid by Other Insurance (if applicable)
30	Yes	Balance Due
31	Yes	Signature of Physician/Practitioner
32	Yes	Name and Address of facility where services were rendered (Site ID). If missing, a claim specialist will choose the site shown as 'primary' in Beacon's database.
32a	No	NPI of Servicing Facility
33	Yes	Provider Name
33a	Yes	Billing Provider NPI
33b	No	Pay to Provider Beacon ID Number

Institutional Services: Instructions for Completing the UB04 Form

Beacon Discourages Paper Transactions

Before submitting paper claims, please review electronic options earlier in this chapter.

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

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

Table 8-6: UB04 Claim Form

Table Block #	Required?	Description
1	Yes	Provider Name, Address, Telephone #
2	No	Untitled
3	No	Provider's Member Account Number
4	Yes	Type of Bill (see Table 7-2 for 3-digit codes)
5	Yes	Federal Tax ID Number
6	Yes	Statement Covers Period (include date of discharge)
7	Yes	Covered Days (do not include date of discharge)
8	Yes	Member Name
9	Yes	Member Address
10	Yes	Member Birthdate
11	Yes	Member Sex
12	Yes	Admission date
13	Yes	Admission Hour
14	Yes	Admission Type
15	Yes	Admission Source
16	Yes	Discharge Hour
17	Yes	Discharge Status (see Table 7-1: Discharge Status Codes)
18-28	No	Condition Codes
29	No	ACDT States
30	No	Unassigned
31-34	No	Occurrence Code and Date
35-36	No	Occurrence Span
37	No	Untitled
38	No	Untitled
39-41	No	Value CD/AMT
42	Yes	Revenue Code (if applicable)
43	Yes	Revenue Description
44	Yes	Procedure Code (CPT) (Modifier may be placed here beside the HCPCS code. See Table 7-3 for acceptable modifiers.)
45	Yes	Service Date
46	Yes	Units of Service
47	Yes	Total Charges
48	No	Non-Covered Charges
49	Yes	Modifier (if applicable – See Table 7-3 for acceptable modifiers)
50	Yes	Payer Name
51	Yes	Beacon Provider ID Number
52	Yes	Release of Information Authorization Indicator
53	Yes	Assignment of Benefits Authorization Indicator
54	Yes	Prior Payments (if applicable)
55	No	Estimated Amount Due

Table Block #	Required?	Description
56	Yes	Facility NPI
57	No	Other ID
58	No	Insured’s Name
59	No	Member’s Relationship to Insured
60	Yes	Member’s Identification Number
61	No	Group Name
62	No	Insurance Group Number
63	Yes	Prior Authorization Number (if applicable)
64	No	Rec ID Number for Resubmitting a Claim
65	No	Employer Name
66	No	Employer Location
67	Yes	Principal Diagnosis Code
68	No	A-Q Other Diagnosis
69	Yes	Admit Diagnosis
70	No	Patient Reason Diagnosis
71	No	PPS Code
72	No	ECI
73	No	Unassigned
74	No	Principal Procedure
75	No	Unassigned
76	Yes	Attending Physician NPI/TPI – First and Last Name (required)
77	No	Operating Physician NPI/TPI
78-79	No	Other NPI
80	No	Remarks
81	No	Code-Code

Paper resubmission

See Table 8-4 for an explanation of claim resubmission, when resubmission is appropriate, and procedural guidelines.

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

Paper submission of 120-day waiver request form

- See Table 8-4 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 *120-Day Waiver Request Form*.
- Complete a 120-*Day Waiver Request 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
  Claims Department/120-Day Waivers
  P. O. Box 1866
  Hicksville, NY 11802-1866

Completion of the 120*-Day Waiver Request Form*

To ensure proper resolution of your request, complete the *120-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 120-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

- For an explanation on adjustments and voids, when these requests are applicable, and procedural guidelines, see Table 8-4.
- ***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.
- 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 Department – Adjustment Requests
  P. O. Box 1866
  Hicksville, NY 11802-1866

Completion of the *Adjustment/Void Request Form*

To ensure proper resolution of your request, complete the *Adjustment/Void Request Form* as accurately and

legibly as possible and include the attachments specified above.

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