Today we are Carelon Behavioral Health. We are working on updating all documents, but some historic references to Beacon may remain.

Our name may be new, but our commitment to you remains the same.

Behavioral Health Policy and Procedure Manual for Providers / Amida Care Health Plan

This document contains chapters 1-7 of Beacon's Behavioral Health Policy and Procedure Manual for providers serving Amida Care Health Plan members. Please see the appendices for details regarding the Beacon services associated with your contracted plan. Additionally, all referenced materials are available on our 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 866.664.7142.

eSERVICES | www.beaconhealthoptions.com

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

Updated June 2021

CONTENTS

Chapter 1

Introduction

1.1. Beacon/Amida Care Health Plan Partnership

1.2. About this Provider Manual

1.3. Introduction to Amida Care Health Plan

1.4. Introduction to Beacon

1.5. Beacon/Amida Care Behavioral Health Program

1.6. Additional Resources and Information

1.1. Beacon/Amida Care Health Plan Partnership

Amida Care Health Plan (Amida Care) has contracted with Beacon Health Strategies, LLC (Beacon) to manage the delivery of mental health and substance use disorder services for Amida Care members. The plan delegates these 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 for acute and diversionary services

1.2. About this Provider Manual

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

The Manual serves as an administrative guide outlining Beacon's policies and procedures 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, and Beacon's level of care criteria (LOCC) are presented separately in Appendix B, accessible only 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 866.664.7142.

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

1.3. Introduction to Amida Care Health Plan

Amida Care's mission is to provide access to comprehensive care and coordinated services that facilitate positive health outcomes and general well-being for our members. Amida Care is a non-profit Medicaid HIV Special Needs Plan (SNP). An HIV SNP is a health plan specifically designed for Persons Living with HIV/AIDS (PLWHA). Amida Care works with its members and providers to improve access to care.

Through assistance by nurse care coordinators, member service representatives, community case managers, and other plan staff, it is easier for members to get the care they need and to stay in care. Comprehensive assistance for members and providers is just a phone call away, 24 hours a day, and seven days a week.

Amida Care was founded by seven Community Based Organizations (CBO's): Harlem United, Housing Works, Project Samaritan AIDS Services (PSI), Promesa, St. Mary's, the Greyston Foundation and Village Care of NY.

Amida Care is a Special Needs Health Plan for Medicaid recipients who:

- Are living with HIV/AIDS
- Live or work in the Amida Care service area: Bronx, Manhattan, and Brooklyn

Members can also enroll their children in the plan whether they are HIV+ or not. Those who have Medicare (SSD) or a Medicaid spend down are not eligible to join Amida Care.

1.4. Introduction to Beacon

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

Presently, the Beacon Health Options family of companies serves more than 48 million individuals on behalf of more than 350 client organizations across the country and in the UK. Most often co-located at the physical location of our plan partners, Beacon's "in-sourced" approach deploys utilization managers, case managers and provider network professionals into each local market where Beacon conducts business. Working closely with our plan partner, this approach facilitates better coordination of care for members with physical, behavioral and social conditions and is designed to support a "medical home" model. Quantifiable results prove that this approach improves the lives of individuals and their families and helps plans to better integrate behavioral health with medical health.

1.5. Beacon/Amida Care Behavioral Health Program

The Amida Care/Beacon mental health and substance use disorder (MH/SUD) program provides members with access to a full continuum of mental 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 health care services, Amida Care and Beacon believe that quality clinical services can achieve improved outcomes for our members.

UNIQUE POPULATIONS COVERED / SERVICES OFFERED

Amida Care is a SNP dedicated to helping PLWHA. As such, all of its members are HIV+/AIDs patients. Beacon will work to ensure the best possible treatment of the specific mental and behavioral health needs (including substance use disorders) of this population.

1.6. Additional Resources and Information

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

1. Return to the Provider Tools page of this website, for detailed information about working with Beacon, frequently asked questions, clinical articles and practice guidelines, and links to additional resources.
2. Call IVR, 888.210.2018, to check member eligibility, number of visits available and applicable co-payments, confirm authorization and get claim status.
3. Log on to eServices to check member eligibility and number of visits available, submit claims and authorization requests, view claims and authorization status, view/print claim reports, update practice information, and use other electronic tools for communication and transactions with Beacon.
4. Email provider.relations@beaconhealthoptions.com
5. Beacon contact information is available on Beacon's website or call 866.664.7142.

Chapter 2

Provider Participation in Beacon's Behavioral Health Network

2.1. Network Operations

Beacon's Network Operations Department, with Provider Relations, is responsible for procurement and administrative management of Beacon's behavioral health provider network. As such, its role includes contracting, credentialing and provider relations functions. Representatives are easily 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 a.m. to 5 p.m. EST on Fridays. Contact Beacon.

2.2. Contracting and Maintaining Network Participation

A "participating provider" is an individual practitioner, private group practice, licensed outpatient agency, or facility that has been credentialed by Beacon and has signed a PSA with Beacon. Participating providers agree to provide mental 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, they may notify the member of their termination, but in all cases Beacon will always notify members when their provider has been terminated.

2.3. Transactions and Communication with Beacon

Beacon's website, www.beaconhealthoptions.com, contains answers to frequently asked questions, 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

To streamline providers' business interactions with Beacon, we offer three provider tools:

1. **eServices**

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

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

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

   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.

2. Interactive Voice Recognition

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

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

3. Electronic Data Interchange

Electronic Data Interchange (EDI) is available for claim submission and eligibility verification directly by provider to Beacon or via an intermediary. For information about testing and set-up for EDI, download Beacon's 837 & 835 companion guides.

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

Beacon also offers member eligibility verification through the 270 and 271 transactions. For technical and business related questions, email edi.operations@beaconhealthoptions.com. To submit EDI claims through an intermediary, contact the intermediary for assistance. If using Emdeon, use Beacon's Emdeon Payer ID and Beacon's Health Plan ID.

TABLE 2-1: ELECTRONIC TRANSACTION AVAILABILITY

TRANSACTION/CAPABILITY	AVAILABLE 24/7		
	ESERVICES	IVR	EDI
Verify member eligibility, benefits, and co-payments	Yes	Yes	Yes (HIPAA 270/271)
Check number of visits available	Yes	Yes	Yes (HIPAA 270/271)
Submit outpatient authorization requests	Yes	No	No
View authorization status	Yes	Yes	No
Update practice information	Yes	No	No
Submit claims	Yes	No	Yes (HIPAA 837)

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

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

COMMUNICATION OF MEMBER INFORMATION

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

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

2.4. Access Standards and Service Availability

TABLE 2-2: APPOINTMENT STANDARDS AND AFTER-HOURS ACCESSIBILITY

TYPE OF APPOINTMENT/SERVICE	APPOINTMENT ACCESS TIME FRAMES AND EXPECTATIONS
General Appointment Standards	
Routine/Non-Urgent Services	Within 14 calendar days
Urgent Care	Within 24 hours
Emergency Services	Immediately, 24 hours per day, 7 days per week
ESP Services	Immediately, 24 hours per day, 7 days per week
Service Availability and Hours of Operation	
On-Call	▪ 24-hour on-call services for all members in treatment ▪ Ensure that all members in treatment are aware of how to contact the treating or covering provider after hours and during provider vacations
Crisis Intervention	▪ Services must be available 24 hours per day, 7 days per week. ▪ Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours. ▪ After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician, agency-affiliated staff, crisis team, or hospital emergency room
Outpatient Services	▪ Outpatient services are authorization exempt. Beacon will pay claims for outpatient services in accordance with standard billing policies procedures.
Interpreter Services	▪ Under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency.

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.

2.5. Beacon's Provider Database

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

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

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

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

Beacon maintains, updates and reports the behavioral health provider network (HPN) to Amida Care Health Plan on a quarterly basis for mandatory submission to the NYS Department of Health. Providers must notify Beacon in the event of any significant change in practice that must be reflected in our HPN database and/or that affects our ability to make appropriate referrals. Examples of practice changes requiring notification include:

- Change in address or telephone number of any service
- Addition or departure of any professional staff
- Change in linguistic capability, specialty or program
- Discontinuation of any covered service
- Change in licensure or accreditation of provider or any of its professional staff; and merger, change in ownership, or change of tax identification number. (Note that Beacon is not required to accept assignment of the PSA to another entity.)

All notifications of practice changes and access limitations should be submitted 90 days before their planned effective date or as soon as the provider becomes aware of an unplanned change or limitation.

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

TABLE 2-3: REQUIRED NOTIFICATIONS

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

TYPE OF INFORMATION	METHOD OF NOTIFICATION	
	ESERVICES	EMAIL
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.

2.7. Adding Sites, Services, and Programs

The PSA is specific to the sites and services for which the provider originally contracted with Beacon.

To add a site, service or program not previously included in the PSA, the provider should 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 its 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, 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.

2.8. Provider Credentialing and Recredentialing

Beacon conducts a rigorous credentialing process for network providers based on Centers for Medicare & Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA) guidelines. All providers must be approved for credentialing by Beacon in order to participate in Beacon's behavioral health services network, and must comply with recredentialing standards by submitting requested information within the specified timeframe. 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 email provider.relations@beaconhealthoptions.com.

TABLE 2-4: CREDENTIALING PROCESSES

INDIVIDUAL PRACTITIONER CREDENTIALING	ORGANIZATIONAL CREDENTIALING
Beacon individually credentials the following categories of clinicians in private or solo or practice settings:	Beacon credentials and recredentials facilities and licensed outpatient agencies as organizations. Facilities that must be credentialed by Beacon as organizations include:

INDIVIDUAL PRACTITIONER CREDENTIALING	ORGANIZATIONAL CREDENTIALING
▪ Psychiatrist ▪ Physician certified in Addiction Medicine ▪ Psychologist ▪ Licensed Clinical Social Workers ▪ Master's Level Clinical Nurse Specialists/ Psychiatric Nurses ▪ Licensed Mental Health Counselors ▪ Licensed Marriage and Family Therapists ▪ Licensed Chemical Dependency Professional ▪ Advanced Chemical Dependency ▪ Certified Alcohol Counselors ▪ Certified Alcohol and Substance/Drug Abuse Counselors ▪ 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	▪ Licensed outpatient clinics and agencies, including hospital-based clinics ▪ Freestanding inpatient mental health facilities – freestanding and within general hospital ▪ Inpatient mental health units at general hospitals ▪ Inpatient detoxification facilities ▪ Other diversionary mental health and substance use disorder services including: 1. Partial hospitalization 2. Day treatment 3. Intensive outpatient 4. Residential 5. Substance use rehabilitation

INDIVIDUAL PRACTITIONER CREDENTIALING

To be credentialed by Beacon, practitioners must be licensed and/or certified in accordance with state licensure requirements, and the license must be in force and in good standing at the time of credentialing or recredentialing. Practitioners must submit a complete practitioner credentialing application with all required attachments. All submitted information is primary-source verified by Beacon; providers are notified of any discrepancies found and any criteria not met and have the opportunity to submit additional, clarifying information. Discrepancies and/or unmet criteria may disqualify the practitioner for network participation.

Once the practitioner has been approved for credentialing and contracted with Beacon as a solo provider or verified as a staff member of a contracted practice, Beacon will notify the practitioner or the practice's credentialing contact of the date on which he or she may begin to serve members of specified 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. 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), 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 mental health counselors are approved to function in all contracted hospital-based, agency/clinic-based and other facility services sites. Behavioral health program eligibility criteria include the following:

- Master's degree or above in a mental health field (including, but not restricted to, counseling, family therapy, psychology, etc.) from an accredited college or university
- An employee or contractor within a hospital or mental health clinic licensed in the state of New York, and that meets all applicable federal, state and local laws and regulations
- Supervised in the provision of services by a licensed independent clinical social worker, a licensed psychologist, a licensed master's-level clinical nurse specialist, or licensed psychiatrist meeting the contractor's credentialing requirements
- Is covered by the hospital or mental health/substance abuse 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.

2.9. Prohibition on Billing Members

Health plan members may not be billed for any covered service or any balance after reimbursement by Beacon except for any applicable co-payment.

Further, providers may not charge the plan 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.

Chapter 3

Members, Benefits, and Member-Related Policies

3.1. Mental Health and Substance Use Disorder Benefits

Amida Care offers benefit programs to people on Medicaid living with HIV and the children of these people. Under the plan, the following levels of care are covered, provided that services are medically necessary, delivered by contracted network providers, and that the authorization procedures in Chapter 5 are followed:

- Inpatient detoxification
- Substance use rehabilitation
- Inpatient mental health
- Emergency services

Beacon will not require Amida Care members to obtain prior authorization for outpatient benefits with participating providers. Beacon will be responsible for processing payment on claims for mental health benefits.

3.2. Member Rights and Responsibilities

MEMBER RIGHTS

The plan and Beacon are firmly committed to ensuring that members are active and informed participants in the planning and treatment phases of their mental health and substance use disorder services. We believe that members become empowered through ongoing collaboration with their health care providers, and that collaboration among providers is also crucial to achieving positive health care outcomes.

Members must be fully informed of their rights to access treatment and to participate in all aspects of treatment planning. All health 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 Clinical/Treatment Information

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

Right to Appeal Decisions Made by Beacon

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

Right to Submit a Complaint or Concern to Beacon

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

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

Right to Contact Beacon Ombudsperson

Members have the right to contact Beacon's Office of Ombudsperson to obtain a copy of Beacon's Member Rights and Responsibilities statement. The Beacon Ombudsperson may be contacted at 866.664.7142 or by TTY at 866.727.9441.

Right to Make Recommendations about Member Rights and Responsibilities

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

MEMBER RESPONSIBILITIES

Members of 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. The back of the health plan identification card highlights the emergency procedures.
- Provide clinical information needed for treatment to their behavioral health care provider
- To the extent possible, understand their behavioral health problems and participate in the process of developing mutually agreed upon treatment goals
- Follow the treatment plans and instructions for care as mutually developed and agreed upon with their practitioners

POSTING MEMBER RIGHTS 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 state license requirements.

INFORMING MEMBERS OF THEIR RIGHTS AND RESPONSIBILITIES

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

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

3.3. Non-Discrimination Policy and Regulations

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

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

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

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

3.4. Confidentiality of Member Information

All providers are expected to comply with federal, state and local laws regarding access to member information. With the enactment of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), members give consent for the release of information regarding treatment, payment and health care operations at the sign-up for health insurance. Treatment, payment and health care operations involve a number of different activities, including but not limited to:

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

MEMBER CONSENT

At every intake and admission to treatment, the provider should explain the purpose and benefits of communication to the member's PCP and other relevant providers. The behavioral health clinician should then ask the member to sign a statement authorizing the clinician to share clinical status information with the PCP and for the PCP to respond with additional member status information. A sample form is available on our website 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.

CONFIDENTIALITY OF MEMBERS' HIV-RELATED INFORMATION

Beacon works in collaboration with Amida Care 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 Amida Care's disease management programs and accepts referrals for behavioral health case management from Amida Care. 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 Amida Care. Beacon will assist behavioral health providers or members interested in obtaining any of this information by referring them to Amida Care'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 NYS laws and guidelines concerning the confidentiality of HIV-related information. According to NYS Public Health Law (PHL), all programs regulated and certified by the NYS Department of Health (DOH) that receive client or patient information related to the Human Immunodeficiency Virus (HIV) or an Acquired Immune Deficiency Syndrome (AIDS) diagnosis must comply with confidentiality provisions of Article 27-F (HIV Confidentiality Law) and NYCRR Part 63.

Beacon ensures compliance with Article 27-F by following these procedures when in receipt of HIV/AIDS related information of a potential or existing enrollee. Any identifiable information regarding an enrollee's health status is maintained in confidential records. Paper records are kept locked, and electronic records are password protected. Information regarding an enrollee's clinical status is exchanged among staff and/or providers only when involving coordination of care, utilization review, claims processing, or quality assurance. Person-identifiable clinical data is shared only with the NYSDOH as required by contract and regulation. Required reports, which may include identifiable HIV health information, consist of encounter and service utilization reporting requirements, chart audit requirements, quality assurance reporting requirements and other quality improvement projects. All staff should, at a minimum, adhere to this policy as part of the treatment standard of all enrollees.

All providers affiliated with Beacon must comply with NYS regulation, including the confidentiality provisions of Article 27-F (HIV Confidentiality Law) and NYCRR Part 63. Participating providers and Beacon staff who obtain HIV-related information of an enrollee in the course of providing health or social services or receive such information through an Authorization for Release of Confidential HIV Related Information shall only release the information to the following: the enrollee; a person to whom disclosure is authorized through the enrollee's Informed Consent; individuals in need of confidential HIV information to provide medical care; authorized personnel of correctional facilities; and the NYS Department of Health.

3.5. Amida Care Member Eligibility

AMIDA CARE MEMBER IDENTIFICATION CARDS

Plan 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.

An Amida Care member card contains the following information:

- Member's name, DOB and sex
- Plan identification number
- PCP name, phone number and ID number
- Pharmacy benefit information

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

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

The following resources are available to assist in eligibility verification:

TABLE 3-1: MEMBER ELIGIBILITY VERIFICATION TOOLS

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

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

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

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

Chapter 4

Quality Management and Improvement Program

4.1. Quality Management and Improvement Program Overview

TABLE 4-1: QM & I PROGRAM OVERVIEW

PROGRAM DESCRIPTION	PROGRAM PRINCIPLES	PROGRAM GOALS AND OBJECTIVES
Beacon administers, on behalf of the 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 health care status of members ▪ Enhance continuity and coordination among behavioral health care providers and between behavioral health and physical health care providers ▪ Establish effective and cost efficient disease management programs, including preventive and screening programs that include assessment of social determinants of health (SDOH), 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

PROVIDER ROLE

Beacon employs a collaborative model of continuous Quality Management and Improvement (QM&I) program, 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 Stakeholders committee, email provider.relations@beaconhealthoptions.com. Members who wish to participate in the Member Advisory Council, should contact the Member Services Department.

QUALITY MONITORING

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

- Site visits
- 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 mental health hospitalization
    - Discharge planning activities
    - Communication with member PCPs, other behavioral health providers, government and community agencies
    - Tracking of potential quality of care (PQOC) concerns, complaints, grievances and appeals.
- Other quality improvement activities

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

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

4.2. Treatment Records

TREATMENT RECORD REVIEWS

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

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

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

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

TREATMENT RECORD STANDARDS

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

TABLE 4-2: TREATMENT DOCUMENTATION STANDARDS

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

	▪ Lack of known allergies and sensitivities to substances are clearly noted.
Medical and Psychiatric History	Treatment record contains the member's medical and psychiatric history including: ▪ Previous dates of treatment ▪ Names of providers ▪ Therapeutic interventions ▪ Effectiveness of previous interventions ▪ Sources of clinical information ▪ Relevant family information ▪ Results of relevant laboratory tests ▪ Previous consultation and evaluation reports
Substance Use Disorder Information	Documentation for any member 12 years and older of past and present use of the following: ▪ Cigarettes ▪ Alcohol ▪ Illicit, prescribed, and over-the counter drugs
Adolescent Depression Information	Documentation for any member 13-18 years was screened for depression ▪ If yes, was a suicide assessment conducted? ▪ Was the family involved with treatment?
ADHD Information	Documentation the members aged 6-12 were assessed for ADHD ▪ Was family involved with treatment? ▪ Is there evidence of the member receiving psychopharmacological treatment?
Diagnostic Information	▪ Risk management issues (e.g., imminent risk of harm, suicidal ideation/intent, elopement potential) are prominently documented and updated according to provider procedures ▪ All relevant medical conditions are clearly documented, and updated as appropriate. ▪ Member's presenting problems and the psychological and social conditions that affect their medical and psychiatric status *A complete mental status evaluation is included in the treatment record, which documents the member's:* a. Affect

	b. Speech c. Mood d. Thought control, including memory e. Judgment f. Insight g. Attention/concentration h. Impulse control i. Initial diagnostic evaluation and DSMIV diagnosis that is consistent with the stated presenting problems, history, mental status evaluation, and/or other relevant assessment information j. Diagnoses updated at least quarterly
Treatment Planning	The treatment record contains clear documentation of the following: ▪ Initial and updated treatment plans consistent with the member's diagnoses, goals and progress ▪ Objective and measurable goals with clearly defined timeframes for achieving goals or resolving the identified problems ▪ Treatment interventions utilized 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
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: a. Clinician's name b. Professional degree c. Licensure d. NPI or Beacon Identification number, if applicable e. Clinician signatures with dates
Additional Information for Inpatient and Diversionary Levels of Care	These elements are required for inpatient medical records: ▪ Referral information (ESP evaluation) ▪ Admission history and physical condition ▪ Admission evaluations ▪ Medication records ▪ Consultations ▪ Laboratory and X-ray reports ▪ Discharge summary and *Discharge Review Form*
Information for Children and Adolescents	A complete developmental history must include the following information: ▪ Physical, including immunizations ▪ Psychological ▪ Social ▪ Intellectual ▪ Academic ▪ Prenatal and perinatal events are noted

4.3. 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.

4.4. Practice Guidelines

Beacon and the plan 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, Schizophrenia and Substance Use Disorders, and posted links to these on our website at https://www.beaconhealthoptions.com/providers/beacon/handbook/clinical-practice-guidelines/. We strongly encourage providers to use these guidelines and to consider these guidelines whenever they may promote positive outcomes for clients. Beacon monitors provider utilization of guidelines through the use of claim, pharmacy and utilization data.

Beacon welcomes provider comments about the relevance and utility of the guidelines adopted by Beacon; any improved client outcomes noted as a result of applying the guidelines; and about providers' experience with any other guidelines. To provide feedback, or to request paper copies of the practice guidelines adopted by Beacon, contact us via email at provider.relations@beaconhealthoptions.com.

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

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

COMMUNICATION BETWEEN OUTPATIENT BEHAVIORAL HEALTH PROVIDERS AND PCPS, OTHER TREATERS	COMMUNICATION BETWEEN INPATIENT/DIVERSIONARY PROVIDERS AND PCPS, OTHER OUTPATIENT TREATERS
Outpatient behavioral health providers are expected to communicate with the member's PCP and other outpatient behavioral health providers if applicable, as follows: ▪ Notice of commencement of outpatient treatment within four visits or two weeks, whichever occurs first	With the member's informed consent, acute care facilities should contact the PCP by phone and/or by fax within 24 hours of a member's admission to treatment. Inpatient and diversionary providers 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:

COMMUNICATION BETWEEN OUTPATIENT BEHAVIORAL HEALTH PROVIDERS AND PCPS, OTHER TREATERS	COMMUNICATION BETWEEN INPATIENT/DIVERSIONARY PROVIDERS AND PCPS, OTHER OUTPATIENT TREATERS
▪ 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* and the **Behavioral Health-PCP Communication Form** available for initial communication and subsequent updates, in Appendix B, or their own form that includes the following information: ▪ Presenting problem/reason for admission ▪ Date of admission ▪ Admitting diagnosis ▪ Preliminary treatment plan ▪ Currently prescribed medications ▪ Proposed discharge plan ▪ Behavioral health provider contact name and telephone number Request for PCP response by fax or mail within three business days of the request to include the following health information: ▪ Status of immunizations ▪ Date of last visit ▪ Dates and reasons for any and all hospitalizations ▪ Ongoing medical illness ▪ Current medications ▪ Adverse medication reactions, including sensitivity and allergies ▪ History of psychopharmacological trials ▪ Any other medically relevant information	▪ Date of discharge ▪ Diagnosis ▪ Medications ▪ Discharge plan ▪ Aftercare services for each type, including: ○ Name of provider ○ Date of first appointment ○ Recommended frequency of appointments ○ Treatment plan Inpatient and diversionary providers should make every effort to provide the same notifications and information to the member's outpatient therapist, if there is one. Acute care providers' communication requirements are addressed during continued stay and discharge reviews and documented in Beacon's member record.

COMMUNICATION BETWEEN OUTPATIENT BEHAVIORAL HEALTH PROVIDERS AND PCPS, OTHER TREATERS	COMMUNICATION BETWEEN INPATIENT/DIVERSIONARY PROVIDERS AND PCPS, OTHER OUTPATIENT TREATERS
Outpatient providers' compliance with communication standards is monitored through requests for authorization submitted by the provider and through chart reviews.	

TRANSITIONING MEMBERS FROM ONE BEHAVIORAL HEALTH PROVIDER TO ANOTHER

If a member transfers from one behavioral health provider to another, the transferring provider must communicate the reason(s) for the transfer along with the information above (as specified for communication from behavioral health provider to PCP), to the receiving provider.

Routine outpatient behavioral health treatment by an out-of-network provider is not an authorized service covered by Beacon. Members may be eligible for transitional care within 30 days after joining the health plan, or to ensure that services are culturally and linguistically sensitive, individualized to meet the specific needs of the member, timely per Beacon's timeliness standards, and/or geographically accessible. If you would like to request an outpatient out-of-network, please contact Amida Care's provider relations at 800.556.0689.

4.6. Member Safety Program

Participating providers are required to report to Beacon within 24 hours all Potential Quality of Care (PQOC) concerns involving members. A copy of the "Reporting a Potential Quality of Care Concern: Provider Form," which includes instructions to submit, can be found on Beacon's Provider Website in the Clinical Forms section.

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

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

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

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

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

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

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

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

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

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

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

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

- Provider inappropriate/unprofessional behavior
  - Inappropriate boundaries/relationship with member
  - Practitioner not qualified to perform services
  - Aggressive behavior
  - Displays signs of cognitive, mental health, or substance use concerns impacting the care being provided
- Clinical practice-related issues
  - Abandoned member or inadequate discharge planning
  - Timeliness, accuracy, or adequacy of diagnosis, assessment, or referral
  - Delay in treatment
  - Effectiveness of treatment
  - Failure to coordinate care or follow clinical practice guidelines
  - Failure to involve family in treatment when appropriate
  - Medication error or reaction
  - Treatment setting not safe

- Access to care-related issues
    - Failure to provide appropriate appointment access
    - Lack of timely response to telephone calls
    - Prolonged in-office wait time or failure to keep appointment
    - Provider non-compliant with American Disabilities Act (ADA) requirements
    - Services not available or session too short
- Attitude and service-related issues
    - Failure to allow site visit
    - Failure to maintain confidentiality
    - Failure to release medical records
    - Fraud and abuse
    - Lack of caring/concern or poor communication skills
    - Poor or lack of documentation
    - Provider/staff rude or inappropriate attitude
- Other monitored events
    - Adverse reaction to treatment
    - Failure to have or follow communicable disease protocols
    - Human rights violations
    - Ingestion of an unauthorized substance in a treatment setting
    - Non-serious injuries (including falls)
    - Property damage and/or fire setting
    - Sexual behavior

Beacon investigates Potential Quality of Care Concerns (PQOC) and uses the data generated to identify opportunities for improvement in the clinical care and service members receive. Beacon tracks and trends PQOC concerns and when necessary, investigates patterns or prevalence of incidents and uses the data generated to identify opportunities for quality improvement.

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

4.7. Fraud and Abuse

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

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

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 his or her employer. The employee is authorized under the FCA to initiate court proceedings for any job-related losses resulting from any such discrimination or retaliation.

Reduced Penalties

The FCA includes a provision that reduces the penalties for providers who promptly self-disclose a suspected FCA violation. The Office of Inspector General self-disclosure protocol allows providers to conduct their own investigations, take appropriate corrective measures, calculate damages and submit the findings that involve more serious problems than just simple errors to the agency. If any member or provider becomes aware of any potential fraud by a member or provider, please contact us at 781.994.7500 and ask to speak to the Compliance Officer.

4.8. Complaints, Grievances, and Appeal of Grievance Resolution

Providers with complaints or concerns should contact Beacon at the number provided below and ask to speak with the clinical manager for the plan. All provider complaints are thoroughly researched by Beacon and resolutions proposed within 20 business days.

If a plan member complains or expresses concern regarding Beacon's procedures or services, plan procedures, covered benefits or services, or any aspect of the member's care received from providers, he or she should be directed to call Beacon's ombudsperson at 866.664.7142 (or TTY at 866.727.9441).

4.9. Complaints and Appeal of Complaint Resolution

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

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

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

All Amida Care member complaints regarding behavioral health providers are investigated by Beacon. Beacon generally contacts the provider and the member to understand the entire context surrounding the complaint. When indicated, Beacon establishes a corrective action plan with the provider to ensure that similar issues do not recur in the future. Complaint information regarding providers is filed by provider and reviewed at the time of recredentialing.

Amida Care members with complaints or concerns regarding Beacon's procedures or service, or any aspect of the member's care received from providers, should follow the procedures below:

FILING A COMPLAINT

1. A member or his or her authorized member representative (AMR) may file a complaint with Beacon by calling toll free 866.664.7142, 24 hours a day, seven days a week, by letter, or in person. (TTY: 866.727.9441)
2. There is no required timeframe within which a complaint must be filed.

COMPLAINT RESOLUTION

1. Expedited complaints shall be resolved within 48 hours after receipt of all necessary information and no more than seven days from the receipt of the complaint. In such cases, the member or member's authorized representative will be provided with notice of the complaint determination by telephone and with written notice within one business day.
2. All other complaints shall be resolved within 45 days after the receipt of all necessary information and no more than 60 days from the receipt of the complaint.

COMPLAINT APPEALS

1. If the member or AMR does not agree with Beacon's complaint resolution, the member or AMR has the right to request a complaint appeal. Additionally, the member has the right to contact the State Department of Health to seek an external review of their complaint, at 518.486.6074.
2. The member or AMR has 60 business days after receipt of the notice of the complaint determination

to file a written complaint appeal.

3. Complaint appeals must be submitted by letter to:

   Beacon Health Options Complaint Appeals Department 500 Unicorn Park Dr., Suite 401
   Woburn, MA 01810

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

Chapter 5

Utilization Management

5.1. Utilization Management

5.1. UTILIZATION MANAGEMENT

The Beacon *utilization management* program encompasses management of care from the point of entry through discharge using objective, standardized, and widely-distributed clinical protocols and enhanced outpatient care management interventions. Specific *utilization management* activities may apply for high-cost, highly restrictive levels of care and cases that represent clinical complexity and risk. *Participating providers* are required to comply with *utilization management policies and procedures* and associated review processes.

Examples of review activities included in Beacon's *utilization management* program are determinations of *medical necessity*, *preauthorization*, *certification*, *notification*, *concurrent review*, *retrospective review*, *care*/*case management*, *discharge planning*, and *coordination of care*.

Utilization Management program includes processes to address:

- Easy and early access to appropriate treatment
- Working collaboratively with *participating providers* in promoting delivery of quality care accordingto accepted best-practice standards
- Addressing the needs of special populations, such as children and the elderly
- Identification of common illnesses or trends of illness
- Identification of high-risk cases for intensive care management
- Screening, education and outreach

Objective, scientifically-based medical necessity criteria and clinical practice guidelines, in the context of *provider* or *member* supplied clinical information, guide the *utilization management* processes.

All utilization management decisions are based on the approved medical necessity criteria. Additionally, criteria is applied with consideration to the individual needs of the member and an assessment of the local delivery system.

1. Individual needs and characteristics of the member include: age, linguistic, or ethnic factors, co-morbidities and complications, progress of treatment, psychosocial situation, and home environment.
2. Characteristics of the local delivery system available to the member include aspects such as availability of alternative levels of care, benefit coverage for the available alternatives, and ability of local providers to provide all recommended services within the estimated length of stay.

Prior to beginning a course of outpatient treatment and/or a non-emergency admission, *providers*/*participating providers* must verify *member* eligibility and obtain *authorization* or *certification*(where applicable). Providers/*participating providers* are strongly encouraged to verify eligibility and benefits and submit *authorization* requests (where applicable) via ProviderConnect.

In order to verify *member* eligibility, the *provider*/*participating provider* will need to have the following information available:

- Patient's name, date of birth, and *member* identification number
- Insured or covered employee's name, date of birth, and *member* identification number
- Information about other or additional insurance or health benefit coverage

Based on the most recent data provided by employer/benefit plan sponsor, benefit plan administrator,and/or where applicable the sponsoring government agency, Beacon will:

- Verify *member* eligibility
- Identify benefits and associated *member expenses* under the *member's* benefit plan
- Identify the *authorization* or certification procedures and requirements under the *member's* benefitplan

Note: Verification of eligibility and/or identification of benefits and *member expenses* are not *authorization* or *certification* or a guarantee of payment.

New and Emerging Technologies

Beacon recognizes the need for knowledge of emerging technologies to provide access to optimum care for *members*. Beacon evaluates these technologies in terms of their overall potential benefits to *members*and in some instances recommends these technologies to clients for inclusion in their respective benefit packages. Examples of new technologies are psychotropic medications or new, approved uses of currentmedications, innovative community service programs and new approaches to provision of psychotherapyand treatment. Beacon has established committees that conduct formal reviews of potential new technologies. The effectiveness of new service technologies will be considered in *medical necessity* decisions.

Treatment Planning

Providers/*participating providers* must develop individualized treatment plans that utilize assessmentdata, address the *member's* current problems related to the behavioral health *diagnosis*, and activelyinclude the *member* and significant others, as appropriate, in the treatment planning process. *CCMs* review the treatment plans with the *providers*/*participating providers* to ensure that they include all elements required by the *provider agreement*, applicable government program, and at a minimum:

- Specific measurable goals and objectives
- Reflect the use of relevant therapies
- Show appropriate involvement of pertinent community agencies
- Demonstrate discharge planning from the time of admission
- Reflect active involvement of the *member* and significant others as appropriate

Providers/*participating providers* are expected to document progress toward meeting goals and objectivesin the treatment record and to review and revise treatment plans as appropriate.

Clinical Review Process

Provider/*participating provider* cooperation in efforts to review care prospectively is an integral part of care coordination activities. Subject to the terms of the *member's* benefit plan and applicable state and/orfederal laws and/or regulations, *providers*/*participating providers* must notify Beacon prior to admitting a *member* to any non-emergency *level of care*. The Mental Health Parity & Addiction Equity Act of 2008 requires that mental health and substance use disorder benefits, provided by group health plans with more than 50 employees, must be available on an equivalent or better basis to any medical or surgical benefits. Some benefit plans, but not all, may fall under this guideline and do not require notification or *authorization* for standard outpatient services. Others may allow for a designated number of outpatient sessions without prior-*authorization*, *certification*, or *notification*. Beacon may request clinical information at various points in treatment to ensure the ongoing need for care and treatment that is appropriate and effective in improving health outcomes for *members*.

In all cases, *providers*/*participating providers* are encouraged to contact Beacon prior to initiating any non-emergency treatment to verify *member* eligibility and to clarify what the *authorization* or *certification* requirements are, if any, for the proposed treatment.

Coverage and payment for services proposed for and/or provided to *members* for the identification or treatment of a *member's* condition or illness is conditioned upon *member* eligibility, the benefits covered under the *member's* benefit plan at the time of service, and on the determination of *medical necessity* of such services and/or treatment. Overpayments made as a result of a change in eligibility of a *member* aresubject to recovery (see Overpayment Recovery section).

Subject to verification of eligibility under the *member's* benefit plan, upon request for *authorization* or *certification* of services, the *CCM* gathers the required clinical information from the *provider*/*participating provider*, references the appropriate medical necessity criteria for the services and/or *level of care*, and determines whether the services and treatment meets criteria for *medical necessity*. The *CCM* may *authorize* or *certify levels of care* and treatment services that are specified as under the *member's* benefitplan (e.g., acute inpatient, residential, partial hospitalization, intensive outpatient, or outpatient).
Authorizations or *certifications* are for a specific number of services/units of services/days and for a specific time period based on the *member*'s clinical needs and provider characteristics. Beacon reserves the right to reject or return authorization requests that are incomplete, lacking in specificity, or incorrectly filled out. Beacon will provide an explanation of action(s) which must be taken by the provider to resubmitthe request.

Beacon is required by the state, federal government, NCQA and the Utilization Review Accreditation Commission (URAC) to render utilization review decisions in a timely manner to accommodate the clinical urgency of a situation. Beacon has adopted the strictest timeframe for all UM decisions to comply with the various requirements.

Beacon's internal timeframes for rendering a UM determination and notifying members of such determination begin at the time of Beacon's receipt of the request. Note, the maximum timeframes mayvary on a case-by-case basis in accordance with state, federal government, NCQA or URAC requirements. Refer to the provider portal and network specific sites for specific plan requirements.

Prior to initial determinations of *medical necessity*, the *member's* eligibility status and coverage under a benefit plan administered by Beacon should be confirmed. If eligibility information is not available in non-emergency situations, a *CCM* may complete a screening assessment and pend the *authorization*/*certification* awaiting eligibility verification. *CCMs* will work with *members* and *providers*/*participating providers* in situations of *emergency*, regardless of eligibility status.

If a *member's* benefits have been exhausted or the *member's* benefit plan does not include coverage for behavioral health services, the *CCM*, in coordination with the provider/*participating provider* as appropriate, will provide the *member* with information about available community support services and programs, such as local or state-funded agencies or facilities, that might provide sliding scale discounts for continuation in outpatient therapy, or where available under the *member's* benefit plan, explore benefitexchanges with the client plan.

Retrospective Review

When a *provider*/*participating provider* requests a *retrospective review* for services previously rendered, Beacon will first determine whether such a *retrospective review* is available under the *member's* benefit plan and request the reason for the *retrospective review* (e.g., *emergency* admission, no presentation of aBeacon *member* identification card, etc.). In cases where a *retrospective review* is available, services will be reviewed as provided for in this *handbook*. In cases where a *retrospective review* is not available under the *member's*

benefit plan and/or and where the *provider*/*participating provider* fails to follow administrative process and requirements for *authorization*, *certification*, and/or *notification*, the request for*retrospective review* may be administratively denied. Subject to any client, government-sponsored health benefit program, and/or benefit plan specific requirements, the chart below references the standard timeframes applicable to the type of review request:

STANDARD DETERMINATION TIME FRAMES

REQUEST TYPE	TIMING	DETERMINATION
Prospective *Urgent*	Prior to treatment	Within 24 hours
Prospective Non-Urgent	Prior to treatment	Within 15 calendar days (14 for contracts governed by *CMS*)
Concurrent *Urgent*	>24 hours of *authorization* expiration	Within 24 hours
Concurrent *Urgent*	<24 hours from *authorization* expiration	Within 72 hours
Concurrent Non-Urgent	Prior to *authorization* term	*Reverts to Prospective*, so within 72 hours/15 calendar days (14 for contracts governedby *CMS*)
Retrospective	After services	Within 30 calendar days

Beacon's procedures for *authorization*, *certification* and/or *notification* apply to services and treatment proposed and/or previously rendered in instances where the *member* benefit plan administered by Beacon is primary and instances where the *member* benefit plan administered by Beacon is secondary.

Beacon, at times, may administer both primary and secondary benefit plans of a given *member*. To avoid possible duplication of the review process in these cases, *providers/participating providers* should notify Beacon of all pertinent employer and other insurance information for the *member* being treated.

Note: Failure to follow *authorization*, *certificatio*n, and/or *notification* requirements, as applicable, may result in administrative denial/non-certification and require that the *member* be held harmless from anyfinancial responsibility for the *provider's*/*participating provider's* charges.

Definition of Medical Necessity

Unless otherwise defined in the *provider agreement* and/or the applicable *member* benefit plan and/or the applicable government sponsored health benefit program, Beacon's reviewers, *CCMs*, *Peer Advisors*, and other individuals involved in Beacon's *utilization management* processes use the following definition of *medical necessity* or *medically necessary* treatment in making *authorization* and/or *certification* determinations as may be amended from time to time:

- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (current *ICD* or *DSM*) that threatens life, causes pain or suffering, or results in illness or infirmity

- Expected to improve an individual's condition or level of functioning
- Individualized, specific and consistent with symptoms and *diagnosis*, and not in excess of patient's needs
- Essential and consistent with nationally accepted standard clinical evidence generally recognizedby mental health or substance abuse care professionals or publications
- Reflective of a level of service that is safe, where no equally effective, more conservative and lesscostly treatment is available
- Not primarily intended for the convenience of the recipient, caretaker or *provider/participating provider*
- No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency
- Not a substitute for non-treatment services addressing environmental factors

Medical Necessity Criteria

Beacon's Medical Necessity Criteria (MNC), also known as clinical criteria, are reviewed and updated atleast annually to ensure that they reflect the latest developments in serving individuals with behavioral health diagnoses. Beacon's Corporate Medical Management Committee (CMMC) adopts, reviews, revises and approves Medical Necessity Criteria per client and regulatory requirements.

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

1. For all Medicare members, first identify relevant Centers for Medicare and Medicaid (CMS) National Coverage Determinations (NCD) or Local Coverage Determinations (LCD) Criteria.
2. If no CMS criteria exists for Medicare members and for all non-Medicare members, identify relevant custom Medical Necessity Criteria.
3. If no custom criteria exists for the applicable level of care and the treatment is substance userelated, the American Society of Addiction Medicine (ASAM) criteria would be appropriate.
   ** Exception: Substance Use Lab Testing Criteria is in InterQual® Behavioral Health Criteria.*
4. If the level of care is not substance use related, Change Healthcare's InterQual® Behavioral Health Criteria would be appropriate.
5. If 1-4 above are not met, Beacon's National Medical Necessity Criteria would be appropriate.

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

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

B. Change Healthcare's InterQual Behavioral Health Criteria

C. American Society of Addiction Medicine (ASAM) Criteria

D. NYS LOCADTR 3.0 (Level of Care for Alcohol and Drug Treatment Referral)

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

F. Beacon's National Medical Necessity Criteria

Network providers are given an opportunity to comment or give advice on development or adoption of medical necessity criteria and on instructions for applying the criteria. These comments and opinions are solicited through practitioner participation on committees and through provider requests for review.

Medical Necessity Criteria is available on Beacon's website via hyperlinks whenever possible and is available upon request. To order a copy of the ASAM criteria, please go to the following website: www.asam.org/PatientPlacementCriteria.html. In addition, Beacon disseminates criteria sets via the website, provider handbook, provider forums, newsletters, and individual training sessions.

For substance use disorder treatment requests for in-network, OASAS licensed providers, notification of the admission to Beacon is required within two business days from the date of admission. The decision to provide treatment or service to a member is the responsibility of the attending provider and the member (his or her patient). If the requesting provider does not provide the necessary information for Beacon to make a medical necessity determination, Beacon will make a determination based on the information received within the specified timeframes, which may result in an adverse determination. The NYS LOCATDR 3.0 tool with be used for level of care determinations for all OASAS services. The LOCADTR tool is available online at https://extapps.oasas.ny.gov.

For in-network providers, treatment requests for all mental health Inpatient, Partial Hospitalization and Intensive Outpatient Program levels of care, notification of admission to Beacon is required within two business days from the date of admission.

As of 01/01/2020, NYS Legislation mandated no UM on Children's Inpatient Mental Health services for individuals 20 and younger for the first 14 days of treatment as long as notification of the admission to Beacon is made within 2 business days. To align with this legislative change, Beacon implemented a Mental Health Notification of Admission (NOA) process for Adult Inpatient Mental Health for in-network providers:

- MH Inpatient (9 day NOA)

and the following for both Adults & Children:

- MH PHP (10 day NOA)
- MH IOP (15 day NOA)

The MH NOA process is for NY in-network providers who submit notification of the admission within 2 business days of the admission date. NY in-network providers who do not submit notification within 2 business days of the admission date, as well as out-of-network providers, will be subject to the standard review process from the time of admission.

Clinical Practice Guidelines

Beacon reviews and endorses clinical practice guidelines on a regular basis to support providers in making evidence-based care treatment decisions on a variety of topics. The most up-to-date, *endorsed, clinical practice guidelines (CPGs) are posted on the Beacon website*. Included are those that have been developed or updated within the past two years and represent the best clinical information we have at thistime. Others clinical practice resources, while not considered current, still contain information that continues to be clinically relevant. For example, some of the guidelines may recommend specific treatment interventions without adequately addressing the sufficiency of the evidence to support the recommendation. Continued use of the guidelines is warranted because resultant positive clinical contribution outweighs the fact that the summaries of the supporting research may have lacked adequate transparency related to the process of ranking the studies necessary to meet today's standards of guideline development.

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

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

Additionally, each year, Beacon measures providers' adherence to at least three (3) Clinical Practice Resources. Beacon has chosen the following two adult-focused and one child-focused Clinical Practice Resources for 2020 national measurement, unless otherwise required by contract. Beacon will review aportion of its members' medical records using the tool posted on the *Beacon website*. Questions were developed from the resources.

As Beacon providers, you are expected to ensure your standards of practice align with the endorsedclinical practice guidelines.

Clinical Care Manager Reviews

CCMs obtain clinical data from the *provider/participating provider* or designee relating to the need for careand treatment planning. The *CCM* evaluates this information and references applicable medical necessitycriteria to determine *medical necessity* of the requested *level of care* or service. Where appropriate, care is *pre-certified* for a specific number of services/days for a specific time period at a specific *level of care*, based on the needs of the *member*.

Except where disclosure of certain information is expressly prohibited by or contrary to applicable state or federal laws or regulations, *participating providers* must be prepared to provide Beacon with the following information at the time of the review, as necessary and appropriate:

UM REVIEW REQUIREMENTS – INPATIENT AND DIVERSIONARY

PRE-SERVICE REVIEW	CONTINUED STAY (CONCURRENT) REVIEW	POST-SERVICE REVIEW
The facility clinician making the request needs the following information for a pre-service review: ▪ Member's health plan identification number ▪ Member's name, gender, date of birth, and city or town of residence ▪ Admitting facility name and date of admission ▪ ICD or DSM diagnosis: (A provisional diagnosis is acceptable.) ▪ Description of precipitating event and current symptoms requiring inpatient psychiatric care ▪ Medication history ▪ Substance abuse history ▪ Prior hospitalizations and psychiatric treatment ▪ Member's and family's general medical and social history ▪ Recommended treatment plan relating to admitting symptoms and the member's anticipated response to treatment ▪ Recommended discharge plan following end of requested service	To conduct a continued stay review, call a Beacon UR clinician with the following required information: ▪ Member's current diagnosis and treatment plan, including physician's orders, special procedures, and medications ▪ Description of the member's response to treatment since the last concurrent review ▪ Member's current mental status, discharge plan, and discharge criteria, including actions taken to implement the discharge plan ▪ Report of any medical care beyond routine is required for coordination of benefits with health plan (Routine medical care is included in the per diem rate.)	Post-service reviews may be conducted for inpatient, diversionary or outpatient services rendered when necessary. To initiate a post-service review, 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.

Inpatient or Higher Levels of Care

All inpatient and alternative *level of care* programs (this does not include outpatient therapy rendered in a *provider's*/*participating provider's* office or outpatient therapy in a clinic or hospital setting) will be subject to the review requirements described in this section. Prior to non-emergency admission and/or beginning treatment, the *provider*/*participating provider* must contact Beacon:

- For *notification*
- To confirm benefits and verify *member* eligibility
- To provide clinical information regarding the *member's* condition and proposed treatment
- For *authorizations* or *certifications*, where required under the *member's* benefit plan and incompliance with state regulations

It is preferred that providers use the *ProviderConnect* web portal, available 24 hours a day, seven days a week (excluding scheduled maintenance and unforeseen systems issues), to confirm benefits and provide notification and clinical information as appropriate. *Providers/participating providers* can secure copies of the *authorization*/certification requests at time of submission for their records. The web portal can be utilized for *concurrent reviews* and discharge reviews as well as initial or precertification reviews.

CCMs and/or referral line clinicians are available 24 hours a day, seven days a week, and 365 days a year and can provide assessments, referrals, and conduct *authorization* or *certification* reviews if such processes are unavailable through ProviderConnect.

Where *authorization*, *certification,* or *notification* is required by the *member's* benefit plan and unless otherwise indicated in the *provider agreement*, *providers*/*participating providers* should contact Beacon within 48 hours of any *emergency* admission for *notification* and/or to obtain any required *authorization* or *certification* for continued stay.

If prior to the end of the initial or any subsequent *authorization* or *certification*, the *provider*/*participating provider* proposes to continue treatment, the *provider*/*participating provider* must contact Beacon by phone or ProviderConnect for a review and recertification of *medical necessity*. It is important that this review process be completed more than 24 hours *prior* to the end of the current *authorization* or *certification* period.

Continued stay reviews:

- Focus on continued severity of symptoms, appropriateness, and intensity of treatment plan, *member* progress, and discharge planning
- Involve review of treatment records and discussions with the *provider/participating provider* or appropriate facility staff, *EAP* staff, or other behavioral health *providers* and reference to the applicable medical necessity criteria

In instances where the continued stay review by a *CCM* does not meet medical necessity criteria and/or where questions arise as to elements of a treatment plan or discharge plan, the *CCM* will forward the case file to a Peer Advisor for review.

Effective January 1, 2017, Medicaid managed care plans (MMCPs) are to comply with New York State Insurance Law (INSL) Section 4303(k)(4), as provided by section three of Part B of Chapter 71 of 2016.This section prohibits prior the need for authorization for inpatient substance use disorder (SUD) treatment when provided in a participating OASAS-certified facility. In addition, it prohibits concurrent utilization review during

the first 28 days of medically necessary inpatient SUD treatment when providedin a participating OASAS-certified facility, and where the MMCP was notified and received an initial treatment plan from the provider within 48 hours of admission. The OASAS facility is also required to provide periodic clinical updates to the MMCP during the stay.

The statute does not guarantee a member 28 days of treatment. After the initial 28 days, utilization review may be performed for any part of the stay; however, medical necessity denials issued under these circumstances may only be made in accordance with LOCADTR and the Medicaid Managed Care Model Contract.

An MMCP may begin utilization review after 48 hours following admission if the initial treatment plan is not received or if it is not received within the required 48-hour timeframe. Coverage requirements for court ordered services and requirements for appropriate discharge planning still apply, as per the Medicaid Managed Care Model Contract. Members are not to be held financially liable for any portion of their inpatient SUD treatment stay not covered by the MMCP. Out-of-network authorization determinations for inpatient SUD treatment services may still be made in accordance with the Medicaid Managed Care Model Contract.

Note: Submission requirements may vary depending on benefit plan; therefore, it is recommended thatthe *provider*/*participating provider* contact customer service by dialing the toll-free number on the *member's* insurance card to obtain the correct procedure:

- *Inpatient Treatment Review* (*ITR*) requests for Acute Mental Health or Acute Detox Services areonly accepted via ProviderConnect for some benefit plans
- Residential, partial, and intensive outpatient service requests should be completed via ProviderConnect
- Some benefit plans only allow telephonic review if ProviderConnect is not utilized
- Some contracts require requests to only be submitted via ProviderConnect

Discharge Planning

Discharge planning is an integral part of treatment and begins with the initial review. As a *member* is transitioned from inpatient and/or higher *levels of care*, the *CCM* will review/discuss with the *provider*/*participating provider* the discharge plan for the *member*. The following information may be requested and must be documented:

- Discharge date
- Aftercare date
    - Date of first post-discharge appointment (must occur within seven days of discharge)
    - With whom (name, credentials)
    - Where (*level of care*, program/facility name)
- Other treatment resources to be utilized:
    - Types
    - Frequency
    - Medications

- Patient/family education regarding purpose and possible side effects
- Medication plan including responsible parties
- Support systems
- Familial, occupational and social support systems available to the patient. If key supports are absent or problematic, how has this been addressed

- Community resources/self-help groups recommended (note purpose)
- *EAP* linkage
- If indicated (e.g., for substance use aftercare, workplace issues, such as Return-to-Work Conference, enhanced wraparound services) indicate how this will occur
- Medical aftercare (if indicated, note plan, including responsible parties)
- Family/work community preparation
- Family illness education, work or school coordination, (e.g., *EAP* and Return-to-Work Conference) or other preparation done to support successful community reintegration. Note specific plan, including responsible parties and their understanding of the plan.

Case Management Services (For select patients who meet high-risk criteria)

As part of the case management program at Beacon, we offer assistance with:

- Discharge planning
- Assessment and integration of service for ongoing needs
- Coordination with behavioral health services
- Collaboration with healthcare providers and caregivers
- Providing information about what benefits might be available
- Medication education and monitoring

Hospitals may be asked for assistance in enrolling patients in case management during inpatient admissions.

When requested, please:

1. Have the patient complete the *authorization* form, with help if needed.
2. Send the *authorization* to Beacon by faxing it to the number on the form.
3. Schedule a discharge appointment within seven days after discharge. If you need help with getting an appointment within seven days, please contact Beacon.

Referrals to Beacon Case Management can be directed to the plan's designated email box AMIDAHARPPOC@beaconhealthoptions.com or members and/or providers can contact Beacon Health Options Customer Service directly at 888-204-5581.

Chapter 6

Clinical Reconsideration and Appeals

6.1. Request for Reconsideration of Adverse Determination

If a plan member or member's provider disagrees with a utilization review decision issued by Beacon, the member, Authorized Member Representative (AMR) 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 or Psychologist 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.

6.2. Clinical Appeal Processes

OVERVIEW

A plan member, AMR 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 representatives as enclosures in all denial letters and upon request.

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

PEER REVIEW

A peer review conversation may be requested at any time by the treating provider, and may occur prior to or after an adverse determination, upon request for a reconsideration. Beacon UR clinicians and Physician and Psychologist Advisors are available daily to discuss denial cases by phone at 866.664.7142.

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 is 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)

When an appeal is requested by someone purporting to represent the member, Beacon requires documentation that the requestor is authorized to act on the member's behalf. If such documentation is not already on file, 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

1. If a Beacon Physician or Psychologist (PhD) Advisor (PA) determines that requested services are not medically necessary, and the PA and attending provider are unable to negotiate a mutually acceptable plan, the Beacon PA will issue an adverse determination. Notifications of adverse actions include the procedure for initiating an appeal and are communicated to enrollees, AMRs, attending providers and/or health care facilities.
2. If an adverse action is made by Beacon and the attending behavioral health provider believes that the determination warrants an immediate reconsideration, Beacon shall provide the opportunity to seek a reconsideration of that determination by telephone with the Beacon PA who made the review determination. The reconsideration must be completed within one business day of the receipt of request.
3. Any party whose adverse action is not resolved through the reconsideration process is offered the opportunity to appeal the decision through the formal internal appeal process.
4. An appeal must be filed within 60 business days of receipt of notification of Beacon's adverse determination. Members are offered the right of representation throughout the appeals process and the opportunity to submit written comments and documents concerning the appeal to the appeals coordinator. Additionally, members are informed that they may have access to, and copies of, documents relevant to the appeal, upon request.
5. After an appeal is submitted either by telephone or in writing, a Beacon appeals coordinator sends out corresponding acknowledgement letters to the member, AMR and/or provider. Acknowledgment letters for standard (non-urgent) appeals are sent within five days of the receipt of appeal request, acknowledging receipt of the appeal and notification that a determination will be made within 30 calendar days. For post-service appeals, acknowledgement letters are sent within five calendar days of receipt of the appeal request, acknowledging receipt of the appeal and notification that a determination will be made within 30 calendar days. Beacon does not send acknowledgment letters for expedited (urgent) appeals.
6. Determination and notification of appeal decisions are communicated to the member, AMR or provider, as appropriate, within the timeframes listed on in Chapter 5, depending upon the nature of the request (pre-service, concurrent or post service) and urgency of the case (urgent or non- urgent).
7. The outcome of a level 1 appeal, if upheld, is considered a Final Adverse Determination (FAD).

CLINICAL APPEAL DECISION AND NOTIFICATION TIMEFRAMES

Decision and notification timeframes start from the time of the request by the member, AMR, or provider.

	PRE-SERVICE REVIEW TIME TO DECISION AND NOTIFICATION	
REVIEW TYPE	RECONSIDERATION	LEVEL 1 APPEAL*
Urgent/Expedited	1 business day	2 business days, no more than 72 hours
Non-Urgent/Standard	N/A	30 calendar days

* If an expedited level 1 appeal is completed and upheld, a level 1 standard appeal may be requested.

CONCURRENT REVIEW TIME TO DECISION AND NOTIFICATION		
REVIEW TYPE	**RECONSIDERATION**	**LEVEL 1 APPEAL**
Urgent/Expedited	1 business day	2 business days, no more than 72 hours
Non-Urgent/Standard	N/A	N/A

POST-SERVICE REVIEW TIME TO DECISION AND NOTIFICATION		
REVIEW TYPE	**RECONSIDERATION**	**LEVEL 1 APPEAL**
Non-Urgent/Standard	30 calendar days	30 calendar days

FAIR HEARING PROCEDURES

Applies to Clinical and Administrative Denials for Medicaid Members

In accordance with SSL 22, 364-j (9), 18 NYCRR 358, all Medicaid recipients shall be afforded the right to a fair hearing under appropriate circumstances. The federal government and the New York State Department of Health require the Fair Hearing provisions. Medicaid recipients are informed of their right to apply to the New York State Department of Health Office of Administrative Hearings when they feel a managed care plan, local Department of Social Services, or a provider has wrongly limited their Medicaid benefits.

Beacon, and the health plans with which it holds contracts, are required to provide information to Medicaid enrollees about their right to a fair hearing whenever the following occurs:

- Requested services are denied because they are not medically necessary or are not part of the covered benefit package
- Requested continued services are denied, reduced, suspended or terminated

Participating providers should be aware of Beacon's policies regarding fair hearings, which comply with applicable regulations. A Medicaid enrollee may be entitled to appeal a Beacon decision sequentially or concurrently through the Beacon appeal process; the New York State external review process; and the New York State Office of Administrative Hearings process. For Medicaid members, the fair hearing decision is ultimately binding.

Inquiries regarding this fair hearing procedure should be directed to the Beacon Clinical Program Manager for Amida Care at 800.556.0689. Questions regarding the fair hearing process may also be directed to the New York Office of Administrative Hearings at 518.474.8781.

EXTERNAL APPEAL PROCESS

Applies to Clinical Denials for Medicaid Members

Members of managed care organizations in New York State have the right to request an external appeal if their health plan denies coverage because a requested health service is not medically necessary. A member or provider may also request an external appeal if a managed care plan denies coverage for an experimental treatment of a life-threatening or disabling condition.

The process for Amida Care members and providers follows:

- A physician/provider requests authorization of a proposed health service or treatment.
- If Beacon denies coverage for the service because it is not medically necessary or because the proposed service is an experimental or investigational treatment, Beacon sends the member and the requesting provider a letter of denial that provides the clinical rationale for the denial of coverage and instructions for requesting a first level appeal.
- If the decision remains unchanged after the appeal, Beacon will send the member and the requesting provider a letter confirming the denial. This letter is called a notice of "final adverse determination," and will include instructions for requesting an external appeal and an External Appeal Application.
- A provider's External Appeal Application must be submitted to the New York State Department of Insurance within 60 days of receiving the final adverse determination. [If both the provider and Beacon agree, the first level of appeal may be waived, and the provider can apply for external review within 60 days of the initial denial of coverage.]
- The NY Department of Insurance will screen applications and assign appeals to an independent, state-approved external appeal agent.
- If a delay in rendering a decision would cause harm to the member, the member's primary care physician/provider (PCP) or other physician/provider will need to submit an attestation along with application for an expedited review.
- The external appeal agent may request information from the member's provider or plan.

The external appeal agent must render a decision on coverage within 30 days for a standard appeal and three days for an expedited appeal. The decision of the external appeal agent is binding on the member, the provider and the plan.

Amida Care members are not required to pay any fees related to an external review. Participating providers may need to assist a member in completing the external appeal application. For appeals that require an urgent decision, providers will need to complete a Physician Attestation Form to be included with the External Appeal Application. The Department of Insurance will review the physician's attestation and determine if the matter should undergo an "expedited" external review. Providers may also complete an application to request an External Review of denied coverage for services that have already been provided.

Amida Care benefits do not include payment for health care services that are not medically necessary. If a service/drug/device has been determined to be medically necessary through the New York State external review process, Beacon will cover the costs of the service/drug/device to the extent that it would otherwise be covered under the member's benefit plan. Similarly, if an external review determines Beacon should cover an experimental or investigational treatment that is part of a clinical trial, Beacon will cover only the costs of the treatment provided to the member under the terms of the trial. Beacon will not be responsible for the costs of investigational drugs or devices or the costs of non-healthcare services, such as the costs of managing research or the costs of collecting data that is useful for the research project but not necessary

for the member's care.

6.3. Administrative Appeal Processes

An administrative denial is an adverse determination issued on a basis other than medical necessity or experimental/investigational services. Appeals of administrative denials are reviewed according to the same process as clinical appeals, except that non-clinical staff may make administrative appeal determinations; a physician/psychologist advisor is not required.

ADMINISTRATIVE APPEAL DECISION AND NOTIFICATION TIMEFRAMES

Resolution and notification (written and oral) of pre-service and concurrent appeals (expedited) will be completed within two business days of receipt of all necessary information and no later than 72 hours of the date of the receipt of the appeal, or as expeditiously as the member's condition requires. Beacon does not send acknowledgement letters for urgent (expedited) appeals. Resolution of non-urgent (standard) pre-service appeals will occur within 30 calendar days of receipt of the request. The notification of the determination will be sent within two business days of the resolution. Resolution of post- service appeals will be completed within 30 calendar days with notification within two business days of determination.

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

Chapter 7

Billing Transactions

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

7.1. General Claims Policies

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

DEFINITION OF "CLEAN CLAIM"

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

ELECTRONIC BILLING REQUIREMENTS

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

PROVIDER RESPONSIBILITY

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

LIMITED USE OF INFORMATION

All information supplied by Beacon or collected internally within the computing and accounting systems of a provider or billing agency (e.g., member files or statistical data) can be used only by the provider in the accurate accounting of claims containing or referencing that information. Any 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.

7.2. Coding

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

- Providers are required to submit HIPAA-compliant coding on all claim submissions, which includes HIPAA-compliant revenue, CPT, HCPCS and ICD-9 codes. Providers should refer to their Exhibit A for a complete listing of contracted, reimbursable procedure codes.
- Beacon accepts only ICD-9 diagnosis codes listing approved by CMS and HIPAA. In order to be considered for payment by Beacon, all claims must have a primary ICD-9 diagnosis in the range of 290-298.9, 300.00-316. All diagnosis codes submitted on a claim form must be a complete diagnosis code with appropriate check digits.

DISCHARGE STATUS CODES

Claims for inpatient and institutional services must include the appropriate discharge status code. Table 7-1 lists HIPAA-compliant discharge status codes.

TABLE 7-1: DISCHARGE STATUS CODES

CODE	DESCRIPTION
01	Discharged to Home/Self-Care
02	Discharged/Transferred to Another Acute Hospital

CODE	DESCRIPTION
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 3-digit bill type codes according to the Table 7-2 below:

TABLE 7-2: BILL TYPE CODES

TYPE OF FACILITY - 1ST DIGIT	BILL CLASSIFICIATION - 2ND DIGIT	FREQUENCY - 3RD DIGIT
1. Hospital	1. Inpatient	1. Admission through Discharge Claim
1. Skilled Nursing Facility	2. Inpatient Professional Component	2. Interim – First Claim
2. Home Health	3. Outpatient	3. Interim – Continuing Claims
3. Christian Science Hospital	4. Diagnostic Services	4. Interim – Last Claim
5. Christian Science Extended Care Facility	5. Intermediate Care – Level I	5. Late Charge Only
6. Intermediate Care Facility	6. Intermediate Care – Level II	6-8. Not Valid

MODIFIERS

Modifiers can reflect the discipline and licensure status of the treating practitioner or are used to make up specific code sets that are applied to identify services for correct payment. Table 7-3 lists HIPAA- compliant modifiers accepted by Beacon. Please see your Exhibit A for modifiers for which you are contracted.

TABLE 7-3: MODIFIERS

HIPAA MODIFIER	MODIFIER DESCRIPTION
AH	Clinical Psychologist
AJ	Clinical Social Worker
HA	Child/Adolescent Program
HB	Adult Program, Non-Geriatric
HC	Adult Program, Geriatric
HD	Pregnant/Parenting Women's Program
HE	Mental Health Program
HF	Substance Use Disorder Program
HG	Opioid Addiction Treatment Program
HH	Integrated Mental Health/Substance Use Disorder Program
HI	Integrated Mental Health and Mental Retardation/Developmental Disabilities
HJ	Employee Assistance Program
HK	Specialized Mental Health Programs for High-Risk Populations
HL	Intern
HM	Less than Bachelor's Degree Level
HN	Bachelor's Degree Level
HO	Master's Degree Level
HP	Doctoral Level
HQ	Group Setting
HR	Family/Couple with Client Present
HS	Family/Couple without Client Present
HT	Multi-disciplinary Team
HU	Funded by Child Welfare Agency

HIPAA MODIFIER	MODIFIER DESCRIPTION
HW	Funded by State Mental Health Agency
HX	Funded by County Local Agency
SA	Nurse Practitioner (this modifier required when billing 90862 performed by a nurse practitioner)
SE	State and/or Federally Funded Programs/Services
TD	Registered Nurse
TF	Intermediate Level of Care
TG	Complex/High Level of Care
TH	Obstetrics
TJ	Program Group, Child and/or Adolescent
TR	School-based Individualized Education Program (IEP) services provided outside the public school district responsible for the student
UK	Services provided on behalf of the client to someone other than the client-collateral relationship
U3	Psychology Intern
U4	Social Work Intern
U6	Psychiatrist (this modifier required when billing for 90862 provided by a psychiatrist)

TIME LIMITS FOR FILING CLAIMS

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

- Within 120 days of the dates of discharge on inpatient claims
- Within 120 days from the last date on an interim bill on an inpatient claim

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.

7.3. Coordination of Benefits

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

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

7.4. Provider Education and Outreach

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

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

HOW THE PROGRAM WORKS

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

CLAIM INQUIRIES AND RESOURCES

Additional information is available through the following resources:

Online

- Chapter 2 of this Manual
- Beacon's Claims Page
- Read About eServices
- eServices User Manual
- Read About EDI
- EDI Transactions - 837 Companion Guide

- EDI Transactions - 835 Companion Guide
- EDI Transactions - 270-271 Companion Guide

Email Contact

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

Telephone

- **Interactive Voice Recognition (IVR): 888.210.2018**
  You will need your practice or organization's tax ID, the member's health plan identification number and date of birth, and the date of service.
- **Claims Hotline: 888.249.0478**
  Hours of operation are 8:30 a.m. to 5:30 p.m. Monday through Thursday, 9:00 a.m. to 5:00 p.m. Friday.
- **Beacon's Main Telephone Numbers**

Provider Relations	888.204.5581
EDI	888.204.5581
TTY	866.727.9441

7.5. Electronic Media Options

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

- **Electronic Data Interchange (EDI)** supports electronic submission of claim batches in HIPAA-compliant 837P format for professional services and 837I format for institutional services. Providers may submit claims using EDI/837 format directly to Beacon or through a billing intermediary. If using Emdeon as the billing intermediary, two identification numbers must be included in the 837 file for adjudication:
  - Beacon's payor ID is 43324.
  - Beacon's health plan-specific ID is 029.
- **eServices** enables providers to submit inpatient and outpatient claims without completing a CMS 1500 or UB04 claim form. Because much of the required information is available in Beacon's database, most claim submissions take less than one minute and contain few, if any errors.
- **IVR** provides telephone access to member eligibility, claim status and authorization status.

7.6. Claim Transaction Overview

Table 7-4 below identifies all claim transactions, indicates which transactions are available on each of the electronic media, and provides other information necessary for electronic completion. Watch for updates as additional transactions become available on EDI, eServices and IVR.

TABLE 7-4: CLAIM TRANSACTION OVERVIEW

TRANSACTION	ACCESS ON:			APPLICABLE WHEN:	TIME FRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
	EDI	ESERVICES	IVR			
Member Eligibility Verification	Y	Y	Y	Completing any claim transaction; and Submitting clinical authorization requests	N/A	N/A
Submit Standard Claim	Y	Y	N	Submitting a claim for authorized, covered services, within the timely filing limit	Within 120 days from the date of service	N/A
Resubmission of Denied Claim	Y	Y	N	Previous claim was denied for any reason except time filing	Within 120 days from 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.
120-Day Waiver* (Request for waiver of timely filing limit)	N	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	Within 120 days from the qualifying event.	Waiver requests will be considered only for these four circumstances. A waiver request that presents a reason not listed here will result in a claim denial on a future EOB. A claim submitted beyond the filing

TRANSACTION	ACCESS ON: EDI	ESERVICES	IVR	APPLICABLE WHEN:	TIME FRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
				reimbursement retroactively ▪ Member was enrolled in health plan retroactively ▪ Services were authorized retroactively ▪ Third party coverage is available and was billed first. (A copy of the other insurance explanation of benefits (EOB) or payment is required.) You still have to be within the filing limit when submitting an EOB for coordination of benefits.		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	N	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	N	Claim was paid to provider in error Provider needs to return the entire	N/A	**Do NOT send a refund check to Beacon.**

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

TRANSACTION	ACCESS ON:			APPLICABLE WHEN:	TIME FRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
	EDI	ESERVICES	IVR			
Obtain Claim Status	N	Y	Y	Available 24/7 for all claims transactions submitted by provider	N/A	Claim status is posted within 48 hours after receipt by Beacon.
View/Print Remittance Advice (RA)	N	N	N	Available 24/7 for all claim transactions received by Beacon	N/A	Printable RA is posted within 48 hours after receipt by Beacon.

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

7.7. Paper Claim Transactions

Providers are encouraged to submit claims where electronic methods are available. Electronic claim transactions take less time and have a higher rate of approval since most errors are eliminated.

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

Mail paper claims to:

Beacon Health Options
Amida Care Claims Department 500 Unicorn Park Drive, Suite 401
Woburn, MA 01801-3393

Beacon does not accept claims transmitted by fax.

Beacon Discourages Paper Transactions

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

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

PROFESSIONAL SERVICES: INSTRUCTIONS FOR COMPLETING THE CMS 1500 FORM

Table 7-5 below lists each numbered block on the CMS 1500 form with a description of the requested information, and indicates which fields are required in order for a claim to process and pay.

TABLE 7-5: CMS 1500 FORM

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

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	Former Control Number (Record ID if applicable)
20	No	Outside Lab?
21	Yes	Diagnosis or Nature of Illness or Injury.
22	No	Medicaid Resubmission Code
23	Yes	Prior Authorization Number (if applicable)
24a	Yes	Date of Service
24b	Yes	Place of Service Code (HIPAA compliant)
24d	Yes	Procedure Code (HIPAA-compliant between 295 and 319) and modifier, when applicable (see Table 7-3 for acceptable modifiers)
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

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

INSTITUTIONAL SERVICES: INSTRUCTIONS FOR COMPLETING THE UB04 FORM

Table 7-6 below lists each numbered block on the UB04 claim form, with a description of the requested information and whether that information is required in order for a claim to process and pay.

TABLE 7-6: 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

TABLE BLOCK #	REQUIRED?	DESCRIPTION
9	Yes	Member Address
10	Yes	Member Birth Date
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	REC.ID for Resubmission
38	No	Untitled
39-41	No	Value CD/AMT
42	Yes	Revenue Code (if applicable)
43	Yes	Revenue Description
44	Yes	Procedure Code (CPT) (Modifier may be placed here beside the HCPCS code. See Table 7-3 for acceptable modifiers.)
45	Yes	Service Date
46	Yes	Units of Service
47	Yes	Total Charges

TABLE BLOCK #	REQUIRED?	DESCRIPTION
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
56	Yes	Facility NPI
57	No	Other ID
58	No	Insured's Name
59	No	Member's Relationship to Insured
60	Yes	Member's Identification Number
61	No	Group Name
62	No	Insurance Group Number
63	Yes	Prior Authorization Number (if applicable)
64	No	Document Control Number
65	No	Employer Name
66	No	Employer Location
67	Yes	Principal Diagnosis Code
68	No	A-Q Other Diagnosis
69	Yes	Admit Diagnosis
70	No	Patient Reason Diagnosis
71	No	PPS Code

TABLE BLOCK #	REQUIRED?	DESCRIPTION
72	No	ECI
73	No	Unassigned
74	No	Principal Procedure
75	No	Unassigned
76	Yes	Attending Physician NPI First and Last Name (Required)
77	No	Operating Physician NPI
78-79	No	Other NPI
80	No	Remarks
81	No	Code-Code

PAPER RESUBMISSION

Beacon Discourages Paper Transactions

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

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

-
- See Table 7-4 for an explanation of claim resubmission, when resubmission is appropriate, and procedural guidelines.
- If the resubmitted claim is received by Beacon more than 120 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 120 days after the date on the EOB. A claim package postmarked on the 120th day is not valid.**

- If the resubmitted claim is received by Beacon within 120 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

- See Table 7-4 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 Form*.
- Complete a *120-Day Waiver Form* for each claim that includes the denied claim(s), per the instructions below.
- Attach any supporting documentation.
- Prepare the claim as an original submission with all required elements.
- Send the form, all supporting documentation, claim and brief cover letter to: Beacon Health Options
  Claim Department / 120-Day Waivers 500 Unicorn Park Drive, Suite 401
  Woburn, MA 01801-3393

Completion of the Waiver Request Form

To ensure proper resolution of your request, complete the 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

Beacon Discourages Paper Transactions

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

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

- See Table 7-4 for an explanation of adjustments and voids, when these requests are applicable, and procedural guidelines.
- **Do not send a refund check to Beacon.** A provider who has been incorrectly paid by Beacon, must request an adjustment or void.
- Prepare a new claim as you would like your final payment to be, with all required elements; place the Rec.ID in box 19 of the CMS 1500 claim form, or box 64 of the UB04 form
- Download and complete the *Adjustment/Void Request Form* per the instructions below.
  - Attach a copy of the original claim.
  - Attach a copy of the EOB on which the claim was paid in error or paid an incorrect amount.
- Send the form, documentation and claim to: Beacon Health Options
  Claim Departments – Adjustment Requests 500 Unicorn Park Drive, Suite 401
  Woburn, MA 01801-3393

To Complete the *Adjustment/Void Request Form*

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

1. **Provider Name**
   Enter the name of the provider to whom the payment was made.
2. **Provider ID Number**
   Enter the Beacon provider ID Number of the provider that was paid for the service. If the claim was paid under an incorrect provider number, the claim must be voided and a new claim must be submitted with the correct provider ID Number.
3. **Member Name**
   Enter the member's name as it appears on the EOB. If the payment was made for the wrong member, the claim must be voided and a new claim must be submitted.
4. **Member Identification Number**
   Enter the plan member ID Number as it appears on the EOB. If a payment was made for the wrong member, the claim must be voided and a new claim must be submitted.

5. **Beacon Record ID number**
   Enter the record ID number as listed on the EOB.
6. **Beacon Paid Date**
   Enter the date the check was cut as listed on the EOB.
7. **Check Appropriate Line**
   Place an “X” on the line that best describes the type of adjustment/void being requested.
8. **Check All that Apply**
   Place an “X” on the line(s) which best describe the reason(s) for requesting the adjustment/void. If “Other” is marked, describe the reason for the request.
9. **Provider Signature**
   An adjustment/void request cannot be processed without a typed, signed, stamped, or computer-generated signature. Beacon will not accept “Signature on file”.
10. **Date**
    List the date that the form is signed.