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 / New York Health and Recovery Plan (HARP) Program

This document contains chapters 1-7 of Beacon's Behavioral Health Policy and Procedure Manual for providers serving New York Health and Recovery Plan (HARP) members. Note that links within the manual have been activated in this revised version. Note that the provider manual will be amended as Beacon's operational policies change. Additionally, all referenced materials are available on this website. Chapters which 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 888.210.2018.

eSERVICES | www.beaconhealthstrategies.com | June 2021 (revised)

The Beacon Provider Manual covers the operations of all entities within the BVO Holdings, LLC corporate structure, including Beacon Health Strategies LLC, Beacon Health Options, Inc., BHS IPA, LLC, and CHCS IPA, Inc.

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Chapter 1

Overview of the HARP Program

1.1. About the HARP Program

A Health and Recovery Plan (HARP) is a special needs plan that focuses on adults with significant behavioral health needs. The plan addresses these needs through the integration of physical health, mental health, and substance use services. In addition to the State Plan Medicaid services offered by mainstream MCOs, the HARP offers access to an enhanced benefit package comprised of 1915(i)-like Home and Community Based services designed to provide the individual with a specialized scope of support services.

Section 1915i of the Social Security Act was established as part of the Deficit Reduction Act of 2005. 1915i afforded States the opportunity to provide HCBS under the Medicaid State Plan without the requirement that Medicaid members need to meet the institutional level of care as they do in a 1915(c) HCBS Waiver. The intent is to allow and encourage states to use the flexibility of HCBS services to develop a range of community based supports, rehabilitation and treatment services with effective oversight to assure quality. These services are designed to allow individuals to gain the motivation, functional skills and personal improvement to be fully integrated into communities. The 1915i option acknowledges that even though people with disabilities may not require an institutional level of care (e.g. hospital, nursing home) they may still be isolated and not fully integrated into society. This isolation and lack of integration may have been perpetuated by approaches to service delivery which cluster people with disabilities, and don't allow for flexible, individualized services or services which promote skill development and community supports to overcome the effects of certain disabilities or functional deficits, motivation and empowerment.

HARP MODEL OF CARE

The HARP model of care is a recovery model. This model emphasizes and supports a person's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance disorders through empowerment, choice, treatment, educational, vocational, housing, and health and well-being goals. Recovery is generally seen in this approach as a personal journey rather than a set outcome, and one that may involve developing hope, a secure base and sense of self, supportive relationships, self-direction, social inclusion, and coping skills.

At a 2004 National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation convened by SAMHSA, patients, health-care professionals, researchers and others agreed on 10 core principles undergirding a recovery orientation. Providers working with HARP eligible members, and especially those providing HCBS Services, must implement processes to ensure clinical work adheres to recovery based principles including but not limited to:

- Self-direction: Consumers determine their own path to recovery.
- Individualized and person-centered: There are multiple pathways to recovery based on individuals' unique strengths, needs, preferences, experiences and cultural backgrounds.
- Empowerment: Consumers can choose among options and participate in all decisions that affect them.
- Holistic: Recovery focuses on people's entire lives, including mind, body, spirit and community.
- Nonlinear: Recovery isn't a step-by-step process but one based on continual growth, occasional setbacks and learning from experience.
- Strengths-based: Recovery builds on people's strengths.

- Peer support: Mutual support plays an invaluable role in recovery.
- Respect: Acceptance and appreciation by society, communities, systems of care and consumers themselves are crucial to recovery.
- Responsibility: Consumers are responsible for their own self-care and journeys of recovery.
- Hope: Recovery's central, motivating message is a better future — that people can and do overcome obstacles.

Beacon will evaluate the use of Recovery Principles in care during both utilization management activities, quality evaluations and chart review processes.

1.2. HARP Enrollment and Eligibility Process

Unlike other Medicaid Redesign initiatives, enrollment in a HARP plan is not "mandatory". This initiative offers potentially eligible individuals the chance to enroll in a qualified plan that offers enhanced benefits. Individuals are then screened for eligibility and a personalized recovery plan is developed that specifies the scope, type and duration of services the member is eligible to receive. Individuals will initially be identified by New York State as potentially needing HARP services on the basis of historical service use. Once a member is identified as HARP eligible, they can enroll in a HARP at any point.

A key goal in this managed care design is to avoid disrupting access to physical health care for individuals already enrolled in a mainstream Plan. Therefore, individuals initially identified as HARP eligible who are already enrolled in an MCO with a HARP will be passively enrolled in that Plan's HARP. This will ensure that Plan members will continue to have access to the same network of physical health services as the new BH benefits are brought into the Plan. As part of the passive enrollment process, these individuals will be informed about HARP benefits as well as their ability to stay in their existing mainstream Plan, choose another HARP or opt out of the HARP plan. Individuals will have 30 days to opt out or switch to a new HARP plan. Once enrolled in a HARP, members will be given 90 days to choose another HARP or return to Mainstream before they are locked into the HARP for nine additional months (after which they are free to change Plans at any time). HARP eligible individuals in an HIV SNP will be able to receive HCBS services through the HIV SNP. They will also be given the opportunity to enroll in another HARP. They will be notified of their HARP eligibility and referred to the NYS Enrollment Broker to help them decide which Plan is right for them.

Individuals initially identified as HARP eligible who are already enrolled in an MCO without a HARP will be notified by their Plan of their HARP eligibility and referred to an enrollment broker to help them decide which Plan is right for them. Individuals enrolled in an MCO without a HARP are not required to dis-enroll from their current plan to join a HARP plan but plan without a HARP are not required to offer 1915 (i) like services.

ELIGIBILITY AND ASSESSMENT – HARP AND HOME AND COMMUNITY-BASED SERVICES

Medicaid members are identified by New York State as a member with a serious condition who may benefit from additional coordination of care and Medicaid Waiver Services (HCBS). Health Plans are notified by NYS of a member's eligibility for HARP and eligibility for a Community Assessment. It must be in compliance with conflict free case management requirements and will determine the level of need, or

eligibility, to have additional services (HCBS) available to them. The assigned Health Homes must develop a Plan of Care indicating the need, as defined by the assessment, of the HCBS services.

All HARP eligible members and/or those members identified as in need of additional support, will receive Plan based case management. Specific triggers that may result in a referral for case management include: Beacon case management can aid in the assessment, identification of providers, timely access to services and the development of their person centered Plan of Care. Additionally, consenting HARP members will be connected to Health Home Care Coordination.

1.3. HARP Program Timeline

ADULT BEHAVIORAL HEALTH MANAGED CARE TIMELINE

New York City Implementation

- July 2015 - First Phase of HARP Enrollment Letters Distributed
    - NY Medicaid Choice enrollment letters will be distributed in three phases:
        - Approximately 20,000 July/August distribution for October enrollment
        - Approximately 20,000 August/September distribution for November enrollment
        - Approximately 20,000 September/October distribution for December enrollment
- October 1, 2015 - Mainstream Plans and HARPs implement non-HCBS behavioral health services for enrolled members
- October 2015-January 2016 - HARP enrollment phases in
- January 1, 2016 - HCBS begin for HARP population

Rest of State Implementation

- April 1, 2016 - First Phase of HARP Enrollment Letters Distributed
- July 1, 2016 - Mainstream Plan Behavioral Health Management and Phased HARP Enrollment Begins

For full details on QMP and HARP, including OMH and OASAS specific guidance, please go to http://www.omh.ny.gov/omhweb/bho/ or the OMH Guidance memo in Attachment 1 at the end of this document.

1.4. Quality Improvement Efforts Focus on Integrated Care

Beacon has integrated behavioral health into its Quality Assessment and Performance Improvement (QAPI) program to ensure a systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of behavioral health services. A special focus of these activities is the improvement of physical health outcomes resulting from the integration of behavioral health into the member's overall care. Beacon will routinely monitor claims, encounters, referrals and other data for patterns of potential over- and under-utilization, and target those areas where opportunities to promote efficient services exist.

1.5. Behavioral Health Services

DEFINITION OF BEHAVIORAL HEALTH

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

ACCESSIBLE INTERVENTION AND TREATMENT

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

- Screen, evaluate, treat and/or refer (as medically appropriate), any behavioral health problem. Primary care providers may treat for mental health and/or substance use disorders within the scope of their practice and bill using DSM and/or ICD codes.
- Inform members how and where to obtain behavioral health services
- Understand that members may self-refer to any behavioral health care provider without a referral from the member's primary care provider

This can be achieved by providing members with access to a full continuum of mental health and substance use disorder services through Beacon's network of contracted providers.

First Episode Psychosis

Providers will assess for and promptly refer members experiencing first episode psychosis to specialty programs or program utilizing evidence based practices for this condition, such as:

OnTrackNY Providers, trained by The Center for Practice Innovations (CPI) at Columbia Psychiatry/NYS Psychiatric Institute, deliver coordinated, specialty care, for those experiencing FEP, including: "psychiatric treatment, including medication; cognitive-behavioral approaches, including skills training; individual placement and support approach to employment and educational services; integrated treatment for mental health and substance use problems; and family education and support" (CPI website). Each site has the ability to care for up to 35 individuals. Requirements:

1. Ages 16-30
2. Began experiencing psychotic symptoms for more than a week, but, less than two years, prior to referral
3. Borderline IQ or above, such that individual is able to benefit from services offered.

Providers who need to refer members for further behavioral health care should contact Beacon.

1.6. HARP Covered Benefits and Services

BEHAVIORAL HEALTH BENEFITS FOR ALL MEDICAID POPULATIONS 21 AND OVER*

- Medically supervised outpatient withdrawal (OASAS services)
- Outpatient clinic and opioid treatment program (OTP) services (OASAS services)
- Outpatient clinic services (OMH services)

- Comprehensive psychiatric emergency program
- Continuing day treatment
- Partial hospitalization
- Personalized Recovery Oriented Services (PROS)
- Assertive Community Treatment (ACT)
- Intensive case management/ supportive case management
- Home Care Coordination and Management
- Inpatient hospital detoxification (OASAS service)
- Inpatient medically supervised inpatient detoxification (OASAS Service)
- Inpatient treatment (OASAS service)
- Rehabilitation services for residential SUD treatment supports (OASAS service)
- Inpatient psychiatric services (OMH service)
- Rehabilitation services for residents of community residences

Services are available through Mainstream, HIV SNP, and HARP Plans in NYC on 10/1/15 and the rest of New York State on 7/1/16.

ADDITIONAL HCBS SERVICES FOR ADULTS MEETING TARGETING AND FUNCTIONAL NEEDS

- Rehabilitation
    - Psychosocial Rehabilitation
    - Community Psychiatric Support and Treatment (CPST)
    - Crisis Intervention
- Peer Supports
- Habilitation
    - Habilitation
    - Residential Supports in Community Settings
- Respite
    - Short-term Crisis Respite
    - Intensive Crisis Respite
- Non-medical transportation
- Family Support and Training
- Employment Supports
    - Pre-vocational
    - Transitional Employment

    - Intensive Supported Employment (ISE)
    - Ongoing Supported Employment
- Education Support Services
- Supports for self-directed care
    - Information and Assistance in Support of Participation Direction
    - Financial Management Services

For additional information on HCBS services please refer to the HCBS Manual, available on the OMH website https://www.omh.ny.gov/omhweb/News/2014/hcbs-manual.pdf or see Chapter 2 of this manual for an overview of the HCBS service definitions and clinical criteria.

1.7. Primary Care Provider Requirements for Behavioral Health

Primary care providers (PCPs) may be able to provide behavioral health services within the scope of their practice. However, PCPs should submit claims to their medical payor and not to Beacon. If an enrollee is using a behavioral health clinic that also provides primary care services, the enrollee may select his or her lead provider to be a PCP. PCPs are required to:

a. Deliver primary care services
b. Supervise and coordinate medically necessary health care of the enrollee, including 24/7 coverage
c. Follow the MCOs' standards of care, which are reflective of professional and generally accepted standards of medical practice
d. Following Medicaid requirements for screening for children and adolescents and Medicaid/FHP behavioral health screening by PCPs for all members, as appropriate
e. Allow the member to select a lead provider to be a PCP if the member is using a behavioral health clinic that also provides primary care services

1.8. Health Plan-Specific Contact Addendum

The following information is available via the health plan-specific contact information available at the end of this provider manual.

- Health plan EDI code
- Beacon hours of operation
- Beacon Ombudsperson phone number
- Beacon TTY number
- Interactive Voice Recognition (IVR)
- Beacon's Member Services phone number
- Beacon Claims Department address and phone number

- Beacon Clinical Appeals Coordinator phone number
- Plan/State required filing notice filing limit
- Beacon Provider Relations phone
- Time limits for filing inpatient and outpatient claims
- State Medicaid office address and phone
- State Fair Hearing Office address and phone
    - Number of days for fair hearing decisions
- State Independent Review Organization address and phone

Chapter 2

HCBSService Descriptions and Level of Care Criteria

2.1. 1915i Home and Community Based Services Review Guidelines and Criteria

Home and Community Based Services (HCBS) provide opportunities for Medicaid beneficiaries with mental illness and/or substance use disorders who are enrolled in the Health and Recovery Plan (HARP) to receive services in their own home or community. Implementation of HCBS will help to create an environment where managed care plans (Plans), Health Home care managers, service providers, plan members and their chosen supporters/caregivers, and government partners help members prevent, manage, and ameliorate chronic health conditions and recover from serious mental illness and substance use disorders.

All HARP eligible members that consent will be linked to a local Health Home (HH) for care coordination. In addition any Medicaid member with a serious mental illness, HIV/AIDS or two chronic medical conditions can also receive Health Home support. Health Home care management is provided by the assigned community mental health agency. The HARP, in partnership with the HHs and HCBS providers, ensures medical and behavioral health care coordination and service provision for its members. The HARP will collaborate with Beacon Health Options to oversee and support the Health Homes and HCBS providers via identified quality and utilization metrics and clinical review to ensure adherence with program specifications as defined by New York State established criteria. Beacon Health Options in collaboration with the HARP utilizes a provider profiling tool that delivers programmatic data to both HHs and HCBS providers. This tool includes outcomes and compliance with HCBS assurances and sub-assurances. The HARP's program oversight includes effectively partnering and engaging with contracted Health Home and HCBS providers to ensure that program operations and service delivery have a consistent focus on key factors that result in quality and efficacious treatment for HARP enrollees.

All HARP eligible members will additionally be assigned a Beacon care manager who will serve at the contact with the Health Home, will review clinical information and collaborate on coordination of care as appropriate.

These review guidelines provide a framework for discussion between HCBS providers and Plans. The review process is a collaboration between all pertinent participants including but not limited to the HH care manager, HCBS provider, Plan and member to review progress and identify barriers or challenges that may be interfering with a reasonable expectation of progress towards the member's chosen goals. These conversations will focus on the member's needs, strengths, and history in determining the best and most appropriate fit of the services. These review guidelines are applied to determine appropriate care for all members. In general, services will be authorized if they meet the specific criteria for a particular service. The individual's needs, choice, and characteristics of the local service delivery system and social supports are also taken into consideration.

HH care managers will determine eligibility for HCBS using a standard needs assessment tool. Procedures for authorizing specific HCBS include:

1. The HH care manager will conduct a brief screening for HCBS eligibility with the member.
2. If the member is eligible for HCBS the HH care manager will complete a full assessment that includes documentation of the member's needs, strengths, goals and preferences.
3. In collaboration, the member and HH care manager will develop a comprehensive and person centered Plan of Care. The Plan of Care will reflect the members assessed and self -reported needs as well as those identified through review claims and case conference with providers when appropriate.

4. The HH care manager will share results of the HCBS assessment and Plan of Care with the Plan for review and feedback.
5. If the member is enrolled with the HH, the HH will link the member with an HCBS provider; if the member is not enrolled with the HH, the Plan will link the member to the HCBS provider. Members will be offered a choice of HCBS providers from within the Plan's network.
6. HCBS Provider(s) will conduct service specific assessment(s) and forward additional information to HH care manager regarding intensity and duration of services. The HH care manager will update the Plan with HCBS provider specific information and present it to the MCO for review and approval.
7. HCBS providers will be required to submit a notification to the Plan when a member has been accepted. The notification must be made before the member begins to receive HCBS. The HCBS provider will present the member's Plan of Care to the Plan for review. Notification will allow for authorization of specific HCBS interventions as well as collaborative monitoring to assure timely and appropriate care coordination. Plan Utilization Management will ensure the member's Plan of Care reflects the member's individual, assessed, and self-reported needs and is aligned with concurrent review protocols.

HH outcome data and analytics including member's level of care, adequacy of service plans, provider qualifications, member health and safety, financial accountability and compliance will be collected in partnership between Beacon and the Plan. Data will be aggregated from various sources including the Medicaid Analytic Provider Portal and from review of claims/utilization.

The following is a description of the various HCBS services. These services should be provided using the principles of recovery orientation, person-centeredness, strengths-based, evidence-based, and delivered in the community and the most integrated settings whenever possible.

2.2. Community Rehabilitation Services

Many of the HCBS services are designed to be provided in clusters that promote recovery along a spectrum, and as such, Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) are designated as a cluster. An appointment to any of the Community Rehabilitation Services should be offered within two weeks of the request:

a. **Psychosocial Rehabilitation (PSR):** PSR services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their behavioral health condition (i.e., SUD and/or mental health). Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's Recovery Plan. The intent of PSR is to restore the individual's functional level to the fullest possible (i.e., enhancing SUD resilience factors) and as necessary for integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention.

b. **Community Psychiatric Support and Treatment (CPST):** CPST includes time-limited goal-directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the individual's Plan of Care and CPST Individual Recovery Plan. The following activities under CPST are designed to help persons with serious mental illness to achieve stability and functional improvement in the following areas: daily living,

finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. CPST is designed to provide mobile treatment and rehabilitation services to individuals who have difficulty engaging in site- based programs who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family of choice in their treatment.

2.3. Vocational Services

Many of the HCBS services are designed to be provided in clusters that promote recovery along a spectrum and as such, Employment Support Services are grouped as a cluster and include Pre- v o c a t i o n a l Services, Transitional Employment, Intensive Supported Employment, and Ongoing Supported Employment. An appointment with Educational/Vocational or Employment Services should be offered to a member within two weeks of the request.

a. **Pre-vocational Services:** Pre-vocational services are time-limited services that prepare a participant for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in competitive work environment as well as in the integrated community settings. Pre-vocational services occur over a defined period of time and with specific person centered goals to be developed and achieved, as determined by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual's person-centered plan of care, Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

b. **Transitional Employment (TE):** This service is designed to strengthen the participant's work record and work skills toward the goal of achieving assisted or unassisted competitive e m p l o y m e n t at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, psychosocial club program certified provider or recovery center. This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

c. **Intensive Supported Employment (ISE):** This service assists individuals with MH/SUD to obtain and keep competitive employment. These services consist of intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service will follow the evidence based principles of the Individual Placement and Support (IPS) model. This service is based on Individual Placement Support (IPS) model which is an evidence based practice of supported employment. It consists of intensive supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the

provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting. Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement.
Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support. Services that consist of intensive supports that enable participants for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting.

d. **Ongoing Supported Employment:** This service is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position. Individual employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

2.4. Crisis Respite Services

Many of the HCBS services are designed to be provided in clusters that promote recovery along a spectrum and as such, Crisis Services- Intensive Crisis Respite and Short-term Crisis Respite are designated as a cluster. These crisis services are part of the HCBS benefit but members will not be required to complete the HCBS Eligibility Evaluation and meet Tier 1 or Tier 2 criteria before receiving the service. HARP members who have not already been screened for HCBS eligibility and who are experiencing a crisis should be offered immediate crisis services as clinically indicated. Connectivity to Crisis Respite Services should be made within 24 hours of the request. For these members, the plan will work with the provider and Health Home care manager to complete an HCBS Eligibility Evaluation within 30 days of discharge from the crisis service, to ensure that the member has access to adequate and appropriate follow-up supports and services.

a. **Short-term Crisis Respite:** This is a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the person's home and community environment without onsite supports including:

   - A mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others
   - A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support

- When there is an indication that a person's symptoms are beginning to escalate

Referrals to Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an inpatient setting. An HCBS Eligibility Screening or Full Assessment is not a prerequisite to receiving Short-Term Crisis Respite Services. A Health Home Individual Plan of Care is not required to access this service. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.

b. **Intensive Crisis Respite:** This is a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms. In addition, the person must be able to contract for safety. Individuals in need of ICR are at imminent risk for loss of functional abilities, and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization. An HCBS Eligibility Screening or Full Assessment is not a prerequisite to receiving Intensive Crisis Respite Services. A Health Home Individual Plan of Care is not required to access this service.

2.5. Education Support Services

Education Support Services are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education Support Services may consist of general adult educational services such as applying for and attending community college, university or other college-level courses. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the participant to participate in an apprenticeship program. Participants authorized for Education Support Services must relate to an employment goal or skill development documented in the service plan. Education Support Services must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. Examples of these goals would include, but not be limited to: tutoring or formal classes to obtain a Test Assessing Secondary Completion (TASC) diploma, vocational training, apprenticeship program or formal classes to improve skills or knowledge in a chosen career, community college, university or any college-level courses or classes. An appointment should be offered within two weeks of request.

2.6. Empowerment Services – Peer Supports

Peer Support services are peer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (e.g. hope and self-efficacy, and community living skills). Peer support uses trauma-informed, non-clinical assistance to achieve long-term recovery from SUD and Mental health issues. Activities included must be intended to achieve the identified goals or objectives as set forth in the participants individualized recovery plan, which delineates specific goals that are flexibly tailored to the participant and attempt to utilize community and natural supports. The intent of these activities is to assist recipients in initiating recovery,

maintaining recovery, sustaining recovery and enhancing the quality of personal and family life in long-term recovery. The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Persons providing these services will do so through the paradigm of the shared personal experience of recovery. An appointment should be offered within one week of request unless appointment is pursuant to emergency or hospital discharge, in which case the standard is five days. Or if Peer Support Services are needed urgently for symptom management then standard is 24 hours.

2.7. Habilitation/Residential Support Services

Habilitation services are typically provided on a 1:1 basis and are designed to assist participants with a behavioral health diagnosis (i.e. SUD or mental health) in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings. These services assist participants with developing skills necessary for community living and, if applicable, to continue the process of recovery from an SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable the participant to integrate full into the community and endure recovery, health, welfare, safety and maximum independence of the participant. Appointments should be offered within two weeks of the request.

2.8. Family Support and Training

Training and support necessary to facilitate engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. This service is provided only at the request of the individual. A person-centered or person-directed, recovery oriented, trauma-informed approach to partnering with families and other supporters to provide emotional and information support, and to enhance their skills so that they can support the recovery of a family member with a substance use disorder/mental illness. The individual, his or her treatment team and family are all primary members of the recovery team. For purposes of this service, “family” is defined as the persons who live with or provide care to a person served on the waiver and may include a parent, spouse, significant other, children, relatives, foster family, or in-laws. “Family” does not include individuals who are employed to care for the participant. Training includes instruction about treatment regimens, elements, recovery support options, recovery concepts, and medication education specified in the Individual Recovery Plan and shall include updates, as necessary, to safely maintain the participant at home and in the community. All family support and training must be included in the individual’s recovery plan and for the benefit of the Medicaid covered participant. Appointments should be offered within two weeks of the request.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
All of the following criteria must be met: 1. The member must be deemed eligible to receive HCBS or HCBS	All of the following criteria must be met: 1. Member continues to meet admission criteria and an	Criteria #1, 2, 3, 4, or 5 are suitable; criteria #6. is recommended, but optional:

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
like services, using the HCBS Eligibility Assessment tool. 2. Where the member has been deemed eligible to receive services, a full HCBS Assessment has been completed to determine these services are appropriate for that individual. 3. An Individual Care Plan (ISP) has been developed, informed and signed by the member, Health Home coordinator, and others responsible for implementation. The POC has been approved by the Plan. 4. The HCBS provider develops an (ICP) that is informed and signed by the member and HCBS provider staff responsible for ISP implementation. 5. The ISP and subsequent service request supports the member's efforts to manage their condition(s) while establishing a purposeful life and sense of membership in a broader community. 6. The member must have the desire and willingness to receive rehabilitation and recovery services as part of their ISP. 7. There is no alternative level of care or co-occurring service that would better address the member's clinical needs as shown in POC and ISP.	alternative service would not better serve the member. 2. Interventions are timely, need based, and consistent with evidence based/best practice and provided by a designated HCBS provider. 3. Member is making measureable progress towards a set of clearly defined goals; Or There is evidence that the service plan is modified to address the barriers in treatment progression 4. There is care coordination with physical and behavioral health providers, State, and other community agencies. 5. Family/guardian/ caregiver is participating in treatment where appropriate.	1. Member no longer meets admission criteria and/or meets criteria for another more appropriate service, either more or less intensive. 2. Member or parent/guardian withdraws consent for treatment. 3. Member does not appear to be participating in the ISP. 4. Member's needs have changed and current services are not meeting these needs. Member's self-identified recovery goals would be better served with an alternate service and/or service level. As a component of the expected discharge alternative services are being explored in collaboration with the member, family members (if applicable), the member's Health Home and HCBS provider and MCO. 5. Member's ISP goals have been met. 6. Member's support system is in agreement with the aftercare service plan.

Chapter 3

Provider Participation

3.1. Network Development and Network Operations

Beacon's Network Development and Network Operations Department is responsible for procurement and administrative management of Beacon's behavioral health provider network, which includes contracting and credentialing functions. Representatives are easily reached by email or by phone between 8:30 a.m. and 5 p.m., Eastern Standard Time (EST), Monday through Friday.

3.2. Contracting and Maintaining Network Participation

A "Participating Provider" is an individual practitioner, private group practice, licensed outpatient agency, New York State designated HCBS provider or facility that has been credentialed by and has signed a Provider Service Agreement (PSA) with Beacon. Participating providers agree to provide mental health and/or substance use services and/ or Home and Community Based Services to members; **have a procedure for monitoring HCBS utilization for each enrollee**; accept reimbursement directly from Beacon according to the rates set forth in the fee schedule attached to each provider's PSA; and adhere to all other terms in the PSA, including this provider manual. Note that New York State law currently requires that effective 10/1/15 in New York City and 7/1/15 in the rest of New York State, Plans must pay 100 percent of the Medicaid fee-for-service (FFS) rate (aka, "government rates") for all authorized behavioral health procedures delivered to individuals enrolled in mainstream Medicaid managed care plans, HARPs, and HIV SNPs when the service is provided by an OASAS and OMH licensed, certified, or designated program. This requirement remains in place for at least two full years. While alternative payment arrangements, in lieu of the FFS rates, may be allowed they require prior approval from OMH and OASAS.

FAIR HEARING PROCESS

Pursuant to the Health Care Quality Improvement Act (HCQIA), any applicable federal or state statutes/regulations, and/or client requirements, it is Beacon's policy that all MDs, DOs, and other practitioners/providers have access to and are informed of a fair hearing process that meets the requirements of the HCQIA.

A. A practitioners' and organizational providers' first level of appeal regarding Beacon's National Credentialing Committee (NCC) decisions is through the Provider Appeals Process.

B. For issues related to professional competence and conduct, MDs, DOs, or any other provider, where required by federal or state statute/regulation or client requirement, are offered a fair hearing (second level of appeal).

C. The practitioner/provider must request a fair hearing in writing within 30 calendar days of the Provider Appeals Committee's determination notification.

D. Fair hearings must be held within 90 days of receipt of the written request, or less as required by applicable federal or state statutes/regulations. The practitioner/organizational provider will receive written notice, via certified mail, of the place, time, and date of the hearing, and any witnesses expected to testify on behalf of Beacon. This notice shall also specify a practitioner's/provider's rights related to the fair hearing, including rights provided under the HCQIA.

E. Beacon's National Networks Management identifies professional peer reviewers who participate as the Fair Hearing Panel, assuring representation of the discipline of the practitioner/provider

requesting the hearing. The hearing panel is composed of a minimum of three panel members, of which the majority will be the same discipline and the same or similar specialty as the health care professional under review. Professional peer reviewers do not have any economic interest adverse to the practitioner/provider requesting the hearing. The Fair Hearing Panel selects an individual mutually acceptable to the practitioner/provider and Beacon to serve as the hearing officer, who may or may not be from the panel and who is also not in direct economic competition with the practitioner/provider involved.

F. Reasonable efforts are made by both the practitioner/provider and Beacon to establish a mutually agreed upon date, time, and location for the fair hearing. The fair hearing may occur telephonically or in person as agreed upon by the participants. The practitioner's/provider's right to a hearing may be forfeited if the practitioner/provider fails, without good cause, to appear.

G. The Fair Hearing Panel reviews all documentation including the NCC's decision, the Provider Appeals Committee's decision, and any additional information supplied by the practitioner/provider and witnesses present at the fair hearing proceedings.

H. The practitioner/provider and Beacon each have the right to legal representation or other person of the practitioner's/provider's choice at the fair hearing proceedings.

I. Beacon records the fair hearing proceedings and makes a written transcript of the proceedings available to the practitioner/provider at their request.

J. During the fair hearing proceeding, the practitioner/provider and Beacon have the right to:

    a. Call, examine, and cross-examine witnesses

    b. Present evidence determined to be relevant by the hearing officer or review panel, regardless of its admissibility in a court of law

    c. Submit a written statement at the close of the proceedings

K. The chairperson of the Provider Appeals Committee provides written notification, via certified mail, of the Fair Hearing Panel's decision to the practitioner/provider within 15 business days of the date of the fair hearing proceedings, including a statement of the basis for the decision.

L. Practitioners/providers may file an appeal with the appropriate state agency if they disagree with the Fair Hearing Panel's decision.

M. All records and documentation, including transcripts, related to the fair hearing proceedings are retained for a minimum of seven years or longer as mandated by federal or state law or individual contract requirements.

3.3. Provider Credentialing and Recredentialing

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

Providers must provide information, in writing, to Beacon of any provider terminations. This information can be sent to the above-provided address. The information needs to be received by Beacon within 90 days of termination from the plan.

Any provider who is excluded from Medicare, Medicaid or relevant state payor program shall be excluded from providing behavioral health services to any Medicare, Medicaid or relevant state payor program members served by Beacon, and shall not be paid for any items or services furnished, directed or prescribed after such exclusion. Beacon verifies applicable education, residency or board status from primary or NCQA-approved sources.

- If a clinician is not board-certified, his/her education and training, including evidence of graduation from the appropriate professional school and completion of a residency or specialty training, are verified. Primary source verification shall be sought from the appropriate schools and training facilities. If the state licensing board or agency verifies education and training with the physician or provider schools and facilities, evidence of current state licensure shall also serve as primary source verification of education and training.

- If the physician states that he/she is board-certified on the application, primary source verification may be obtained from the American Board of Medical Specialties, the American Osteopathic Association, the American Medical Association Master File, or from the specialty boards.

The following will also be included in the physician or individual provider's credentialing file:

- Malpractice history from the National Practitioner Data Bank
- Information on previous sanction activity by Medicare and Medicaid
- Copy of a valid Drug Enforcement Agency (DEA) and Department of Public Safety Controlled Substance permit, if applicable
- Evidence of current, adequate malpractice insurance meeting the HMO's requirements
- Information about sanctions or limitations on licensure from the applicable state licensing agency or board
- Federal Disclosure of Ownership Form

The practitioner will be notified of any problems regarding an incomplete credentialing application, or difficulty collecting requested information or of any information obtained by Beacon during the credentialing process that varies substantially from the information provided to Beacon.

In the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner, a certified letter requesting that the practitioner provide with additional written information with respect to the identified discrepancy within five working days from receipt of the letter. Beacon will allow the provider to correct erroneous information collected during the credentialing process.

Upon receipt of an application, a Network Department staff member reviews the application for completeness.

a. Applications found to be incomplete will either be sent back to the provider with a letter indicating the specific missing information or up to three outreach calls will be made to obtain the missing information.

b. The practitioner will be given 10 - 30 days to respond to initial notice. Specific time frame to respond will be indicated in the notice.

    i. If the practitioner fails to respond within this time frame, Beacon may elect to discontinue the credentialing process.

ii. If Beacon elects to terminate the credentialing process, Beacon will notify the practitioner in writing.

If a site visit is required, the site visits shall consist of an evaluation of the site's accessibility, appearance, space, and the adequacy of equipment, using standards developed by Beacon. In addition, the site visit shall include a review of medical record-keeping practices and confidentiality requirements. Beacon does not complete a site visit for clinicians or group on initial credentialing except for cause.

HOME AND COMMUNITY BASED PROVIDER DESIGNATION

In order to provide HCBS to Beacon HARP eligible individuals, a program must be designated by New York State to provide a specific service and contracted by Beacon to provide that service.

For Behavioral Health HCBS designated Providers, Beacon will ask for an application and HCBS service attestation to be filled out to collect the information necessary to complete plan integrity checks and ensure individuals and organizations are not excluded by Medicare or Medicaid. Beacon will conduct the following checks:

- NPDB
- OIG Exclusion
- OMIG Exclusion
- SAM Exclusion
- New York DOH HCBS Designation List Check

OMH-LICENSED AND OASAS CERTIFIED BEHAVIORAL HEALTH PROVIDERS

When credentialing OMH-licensed, OMH-operated and OASAS-certified providers, Beacon will accept OMH and OASAS licenses and certifications in place of the credentialing process for individual employees, subcontractors or agents of such providers. Beacon collect and will accept program integrity related information as part of the licensing and certification process.

Beacon requires that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

RECREDENTIALING

Recredentialing procedures for the physicians and individual providers shall include, but are not limited to, the following sources:

- Licensure
- Clinical privileges
- Board certification
- Beacon shall query the National Practitioner Data Bank and obtain updated sanction or restriction information from licensing agencies, Medicare, and Medicaid.
    - Beacon does not perform site visits on practitioners or groups for recredentialing. A site visit may be requested if the practitioner meets the threshold established for number of complaints received. Site visits, medical record audits, including evaluation of the quality of encounter notes, are performed randomly by the Clinical Department for quality of care and

compliance review. These site visits are not performed by the Network Management Department, except for those facilities that are not accredited at the time of recredentialing.

The practitioner will be notified of any problems regarding an incomplete credentialing application, difficulty collecting requested information, or of any information obtained by Beacon during the credentialing process that varies substantially from the information provided to Beacon.

In the event that recredentialing information obtained from other sources varies substantially from that provided by the practitioner, the medical director will be informed of the variance. The medical director will send the practitioner a certified letter requesting that the practitioner provide the medical director with additional written information with respect to the identified discrepancy within five working days from receipt of the letter. Beacon will allow the practitioner to correct erroneous information collected during the credentialing process.

3.4. 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 (TJC), Council on Accreditation of Services for Family and Children (COA), Healthcare Facilities Accreditation Program (HFAP), Accreditation Associated for Ambulatory Health Care (AAAHC), Community Health Accreditation Partner (CHAP), 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:

For AmidaCare, Affinity, and MetroPlus Plans:

- 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 AND eligible for licensure to practice independently in the state in which he/she works
- 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

For Emblem Health and VNSNY Plans:

- 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 AND licensed to practice in the state in which he/she works.

- Interns and non-licensed or certified clinicians are not accepted
- 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.

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

3.5. Credentialing Process Overview

INDIVIDUAL PRACTITIONER CREDENTIALING	ORGANIZATIONAL CREDENTIALING
Beacon individually credentials the following categories of clinicians in private or solo or practice settings: ▪ Licensed Psychiatrist ▪ Physician certified in addiction medicine ▪ Licensed Psychologist ▪ Licensed Independent Clinical Social Worker ▪ Licensed Independent Counselor ▪ Master's-Level Clinical Nurse Specialists/Psychiatric Nurses ▪ Licensed Mental Health Counselors ▪ Licensed Marriage and Family Therapists ▪ Other behavioral healthcare specialists who are master's level or above and who are independently licensed, certified, or registered by the state in which they practice	Beacon credentials and recredentials facilities and licensed outpatient agencies as organizations. Facilities that must be credentialed by Beacon as organizations include: ▪ Licensed outpatient clinics and agencies, including hospital-based clinics ▪ Freestanding inpatient 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

3.6. Waiver Request Process

On occasions in which a provider possesses unique skills or abilities but does not meet the above credentialing criteria, a Beacon Waiver Request Form should be submitted. These waiver request forms

will be reviewed by the Beacon Credentialing Committee, and providers will be notified of the outcome of the request.

3.7. Provider Training

TRAINING PROGRAM OVERVIEW

To prepare our providers for the program, we are developing materials and a training curriculum specific to this program. Many of the materials will be developed in collaboration with OMH and the RPCs. This program will offer providers the skills, and expertise to comply with the requirements under managed care. This program will transition as a foundation for ongoing new provider credentialing and re- credentialing.

This training provides an overview of HCBS including:

- Overview and purpose of the waiver services
- Medical necessity
- Prior authorization process
- Care planning – person-centered planning process
- Independent evaluations
- Qualifications for providers
- What is a critical incident and what are the reporting requirements
- Claims submission

Beacon will reach out electronically to all providers to provide a schedule of offered training sessions. Most trainings will either be live webinars or self-paced Web training. There will be some in person training sessions based on the provider.

TIMING

- **Go Live:** For go-live, training will occur, at the earliest between four to six weeks prior to go-live and up through six weeks post-go-live. All live trainings will be offered multiple times to best fit the time for the providers. For more guidelines on specific courses, see the attached detailed agenda.
- **New Providers:** After go-live, as part of the part of the credentialing process, new providers will be directed to enroll and complete the trainings housed on the learning management system. Completion reports will be completed on a monthly basis.
- **Orientation:** Live orientation training will occur on a pre-scheduled monthly basis after go-live.
- **Annual training:** Providers will receive reminders to take the required annual training online.
- **Recredentialing:** As part of the recredentialing process, providers will receive their recredentialing packet and recredentialing training schedule approximately three months prior to their re-credentialing date.

STANDARD TRAINING TIMELINE

New Providers

TIMELINE	TOPIC	NOTES
Four to six weeks prior to credentialing	Credentialing	Once a provider starts the credentialing process, they will be provided with a schedule of offered credentialing trainings that they can attend.
Within 30 days of provider go live	Provider Orientation	Providers are offered multiple session which the can attend.
Within 30 days of provider go live	New Provider Curriculum	Providers receive their curriculum and instructions on how to register for the Learning Management System.

Annual Trainings

Ninety (90) days prior to the annual training date, providers will receive a reminder of their requirements and topics required.

CULTURAL COMPETENCY

Beacon understands that we serve diverse communities and that a key underpinning of serving members is based on cultural competency and the understanding of how it affects treatment outcomes. Therefore, we ensure that all of our training programs reflect these concepts to ensure that the approach to service includes these concepts. The cultural competency and diversity training has been edited to support the varied populations identified in NYC. We will continue to ensure that this training remains up-to-date as population demographics change.

Chapter 4

Encounter Data and Submitting HCBS Billing and Claims

4.1. General Claims Policies

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. Please note that Beacon does not accept claims submitted by facsimile.

Beacon wants to ensure that all providers understand and are aware of the guidelines that Beacon has in place for submitting a claim. Beacon's Provider Relations staff will train provider claims staff on an individual and/or group basis at time intervals that are appropriate to each provider. In the event that you or your staff may need additional or more frequent training, please contact Beacon.

Beacon also encourages providers to take advantage of provider training offered by the Managed Care Technical Assistance Center. Training material and a list of current trainings is available at https://www.mctac.org.

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

DEFINITION OF A "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 data elements, and when applicable, substantiating documentation of particular circumstance(s) warranting special treatment without which timely payments on the claim would not be possible. All claims received by Beacon will be paid or denied within 30 days of receipt determined by the day Beacon receives the claim.

TIME LIMITS FOR FILING CLAIMS

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

- **Outpatient claims:** Please refer to the health plan-specific contact information at the end of this manual for the filing limit for your health plan.
- **Inpatient claims:** Please refer to the health plan-specific contact information at the end of this manual for the filing limit for your plan.

Providers are encouraged to submit claims as soon as possible for prompt adjudication. Claims submitted after the filing limit will deny. Please refer to the health plan-specific contact information at the end of this manual for the filing limit associated with your plan.

ICD-10 COMPLIANCE

International Classification of Diseases, 10th Edition, referred to as ICD-10 coding, was implemented industry-wide October 1, 2015 replacing ICD-9, the current set of diagnosis and procedure codes. This transition to ICD-10 affects everyone covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

NOTE: All claims submitted with dates of service on and after October 1, 2015 must only include ICD-10 codes. Claims submitted without the appropriate ICD 10 codes will result in denials.

4.2. Electronic Billing

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.

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

- **Electronic Data Interchange (EDI)** supports electronic submission of claim batches in HIPAA-compliant 837P format for professional services and 837I format for institutional services. Providers may submit claims using EDI/837 format directly to Beacon or through a billing intermediary. If using Emdeon as the billing intermediary, two identification numbers must be included in the 837 file for adjudication:
    - Beacon's payor ID is 43324
    - Your Health Plan's EDI Code. Please refer to the health plan-specific contact information at the end of this manual for your Plan ID.
- **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. Please call Beacon's Provider Relations for additional information on eServices.

ADDITIONAL INFORMATION AVAILABLE ONLINE:

- 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

VALUEOPTIONS' CONTRACTED PROVIDERS

The following electronic solutions are available to assist providers in complying with ValueOptions' E-commerce initiative:

ProviderConnect

Links to information and documents important to providers are located here at the Provider section. ProviderConnect is a secure, password protected site where participating providers conduct certain online activities with ValueOptions directly 24 hours a day, seven days a week (excluding scheduled maintenance and unforeseen systems issues). Currently, participating providers are provided access to the following online activities: authorization or certification requests for all levels of care, concurrent review requests and discharge reporting, single and multiple electronic claims submission, claim status review for both paper and electronic claims submitted to ValueOptions, verification of eligibility status, submission of inquiries to ValueOptions Provider Customer Service, updates to practice profiles/records, and electronic access to authorization/certification letters from ValueOptions and provider summary vouchers.

Clearinghouses

Electronic claim submission is also accepted through clearinghouses. When using the services of a Clearinghouse, providers must reference ValueOptions' Payer ID, FHC & Affiliates, to ensure ValueOptions receives those claims.

PaySpan® Health

ValueOptions providers/participating providers must use PaySpan Health, the largest healthcare payment and reimbursement network in the United States, for electronic fund transfer. PaySpan Health enables providers to receive payments automatically in their bank account of choice, receive email notifications immediately upon payment, view remittance advices online, and download an 835 file to use for auto-posting purposes.

ValueOptions Electronic Data Interchange (EDI) Claims Link for Windows® Software

The EDI Claims Link for Windows application is another tool providers or their designated representatives have to submit HIPAA compliant electronic claims. This tool requires installation on a computer and creation of a database of providers and members. Refer to the EDI Claims Link for Windows User Manual located on ValueOptions.com

ValueOptions.com

ValueOptions' website (www.valueoptions.com) contains information about ValueOptions and its business. Links to information and documents important to providers are located here at the Provider section, including additional information pertaining to ValueOptions' E-commerce Initiative.

Access to ProviderConnect and Achieve Solutions is available here as well.

ValueOptions' Notice of Privacy of Practices regarding use of the website is located on the website.

Claim Submission Guidelines

Unless otherwise identified in the provider agreement, participating providers must file or submit claims within ninety (90) calendar days from the date of service or the date of discharge for inpatient admission, or where applicable from date of determination by the primary payor. Claims after the above noted ninety (90) day time period after the date of service may be denied due to lack of timely filing. Claims must match the authorization or certification or notification applicable to covered services for which the claim applies to avoid potential delays in processing. To electronically submit claims, ValueOptions participating providers are required to use ProviderConnect or one of the electronic claims resources detailed further in the section titled "Electronic Resources," to conduct claim submission. These resources will expedite claims processing.

Participating providers should not submit claims in their name for services that were provided by a physician's assistant, nurse practitioner, psychological assistant, intern or another clinician. In facility or program settings, supervising clinicians should not submit claims in their name for services that were provided by a resident, intern or psychological assistant.

Separate claim forms must be submitted for each member for whom the participating provider bills and it must contain all of the required data elements. Each billing line should be limited to one date of service and one procedure code.

When billing for CPT codes that include timed services in the code description (e.g. 90832; 90833; 90834; 90836; 90837; 90838; 90839 and appropriate Evaluation and Management codes, the actual time spent must clearly be documented within the member's treatment record. This time should be documented indicating a session's start and stop times (e.g., 9:00-9:50).

Claims for covered services rendered to members are required to be submitted electronically through ProviderConnect or by using one of the electronic claims resources detailed further in the section titled "Electronic Resources".

Note: If a participating provider uses a clearinghouse to electronically submit claims, please provide the clearinghouse with ValueOptions' payer id, FHC & Affiliates.

All billings by the participating provider are considered final unless adjustments or a request for review is received by ValueOptions within the time period identified in the provider agreement, or if no time period is identified in the provider agreement within 60 calendar days from the date indicated on the Explanation of Benefits (EOB). Payment for covered services is based upon authorization, certification or notification (as applicable), coverage under the member's benefit plan and the member's eligibility at the time of service.

Note: Client plan or government sponsored health benefit program specific claim submission requirements are located in the 'Provider' section of the website under 'Network-Specific.' Additional information for ValueOptions can be located in the Provider Handbook, section 5.0 – Electronic Resources and Claims Submission Guidelines in section 13.0 – Claims Procedures & E-Commerce Initiative.

CLAIMS TRANSACTION OVERVIEW

The table below identifies all claims transactions and 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.

TRANSACTION	EDI	ESERVICES	IVR	APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
Member Eligibility Verification	Y	Y	Y	▪ Completing any claim transaction; ▪ Submitting clinical authorization requests	N/A	N/A
Submit Standard	Y	Y	Y	▪ Submitting a claim for	Within the plan's filing limit	N/A

TRANSACTION	EDI	ESERVICES	IVR	APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
Claim				authorized, covered services, within the timely filing limit	from the date of service. Please refer to the health plan-specific contact information at the end of this manual for the filing limit.	
Resubmission of Denied Claim	Y	Y	Y	Previous claim was denied for any reason except timely filing	Within the plan's filing limit from the date on the EOB. Please refer to the health plan-specific contact information at the end of this manual for the filing limit.	▪ Claims denied for late filing may be resubmitted as reconsiderations. ▪ Rec ID is required to indicate that claim is a resub-mission.
Waiver* (Request for waiver of timely filing limit) *Please refer to the health plan-specific addendum for your plan's filing limit)*	N	N	N	A claim being submitted for the first time will be received by Beacon after the original plan filing limit (please refer to the health plan-specific addendum for your plan's filing limit , and must include evidence that one of the following conditions is met: ▪ Provider is eligible for	Within the filing limit) from the qualifying event. Please refer to the health plan-specific contact information at the end of this manual for your plan's filing limit.	▪ 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 limit that does not meet the above criteria may be submitted as a

TRANSACTION	EDI	ESERVICES	IVR	APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
				reimbursement retroactively ▪ Member was enrolled in health plan retroactively ▪ Services were authorized retroactively ▪ Third party coverage is avail- able 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.		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 the filing limit from the date of payment or nonpayment. Please refer to the health plan-specific contact information at the end of this manual for the	Future EOB shows "Reconsideration Approved" or "Reconsideration Denied" with denial reason

TRANSACTION	EDI	ESERVICES	IVR	APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
					plan's filing limit.	
Request to Void Payment	N	N	N	▪ Claim was paid to provider in error; and ▪ Provider needs to return the entire paid amount to Beacon	N/A	Do NOT send a refund check to Beacon
Request for Adjustment	Y	Y	Y	The amount paid to provider on a claim was incorrect Adjustment may be requested to correct: ▪ Underpayment (positive request); or ▪ Overpayment (negative request)	Positive request must be received by Beacon within the plan's filing limit) from the date of original payment. Please refer to the health plan-specific contact information at the end of this manual for the plan's filing limit. 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, re-payment 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

TRANSACTION	EDI	ESERVICES	IVR	APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
						incorrect adjustment ▪ Claims that have been denied cannot be adjusted, but may be resubmitted.
Obtain Claim Status	N	Y	Y	Available 24/7 for all claims transactions submitted by provider	N/A	Claim status is posted within 48 hours after receipt by Beacon.
View/Print Remittance Advice (RA)	N	N	N	Available 24/7 for all claims 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.*

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.

4.3. Paper Claims Transactions

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

For paper submissions, providers are required to submit clean claims on the National Standard Format CMS 1500 or UB04 claim form. No other forms are accepted.

WHERE TO SEND CLAIMS

Please refer to the health plan-specific addendum for the Beacon claims address associated with your plan.

Providers should submit Emergency Services claims related to behavioral health for processing and reimbursement consideration. Please refer to the health plan-specific contact information at the end of this manual for the Beacon claims address associated with your plan.

Mental Health Institutional facility services claims must be submitted to Beacon electronically using the **837(I)** or Institutional paper claims using **UB04** claim form.

Professional services claims must be submitted electronically using the **837(P), online provider portal**, or paper using the **CMS 1500** claim form.

Instructions for completion of each claim type are provided below.

Professional Services: Instructions for Completing the CMS 1500 Form

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

TABLE BLOCK #	REQUIRED?	DESCRIPTION
1	No	Check Applicable Program
1a	Yes	Member's ID Number
2	Yes	Member's Name
3	Yes	Member's Birth Date and Sex
4	No	Insured's Name
5	Yes	Member's Address
6	No	Member's Relationship to Insured
7	No	Insured's Address
8	No	Member's Status
9	No	Other Insured's Name (if applicable)
9a	No	Other Insured's Policy or Group Number
9b	No	Other Insured's Date of Birth and Sex
9c	No	Employer's Name or School Name
9d	No	Insurance Plan Name or Program Name

TABLE BLOCK #	REQUIRED?	DESCRIPTION
10a-c	No	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	No	Member's or Authorized Person's Signature and Date on File
13	No	Member's Authorized 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	No	Additional Claim Information (Designated by NUCC), if applicable. (Record ID if applicable)
20	No	Outside Lab?
21	Yes	Diagnosis or Nature of Illness or Injury. Enter the applicable ICD indicator according to the following: 9 – ICD-9 diagnosis or 0 – ICD-10-CM diagnosis
22	No	Medicaid Resubmission Code or Former Control Number
23	No	Prior Authorization Number (if applicable)
24a	Yes	Date of Service
24b	Yes	Place of Service Code (HIPAA-compliant)
24d	Yes	Procedure Code and modifier, when applicable

TABLE BLOCK #	REQUIRED?	DESCRIPTION
24e	Yes	Diagnosis Code Pointer – 1, 2, 3, or 4
24f	Yes	Charges
24g	Yes	Days or Units
24h	No	EPSDT
24i	No	ID Qualifier
24j	Yes	Rendering Provider Name and Rendering Provider NPI
25	Yes	Federal Tax ID Number
26	No	Provider's Member Account Number
27	No	Accept Assignment (check box)
28	Yes	Total Charges
29	No	Amount Paid by Other Insurance (if applicable)
30	No	Balance Due
31	Yes	Signature of Physician/Practitioner
32	Yes	Name and Address of Facility where services were rendered (Site ID). If missing, a claim specialist will choose the site shown as 'primary' in Beacon's database.
32a	No	NPI of Servicing Facility
33	Yes	Provider Name
33a	Yes	Billing Provider NPI
33b	No	Pay to Provider Beacon ID Number

Institutional Services: Instructions for Completing the UB04 Form

The table 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 BLOCK #	REQUIRED?	DESCRIPTION
1	Yes	Provider Name, Address, Telephone #

TABLE BLOCK #	REQUIRED?	DESCRIPTION
2	No	Untitled
3	No	Provider's Member Account Number
4	Yes	Type of Bill (3-digit codes)
5	Yes	Federal Tax ID Number
6	Yes	Statement Covers Period (include date of discharge)
7	No	Covered Days (do not include date of discharge)
8	Yes	Member Name
9	Yes	Member Address
10	Yes	Member Birthdate
11	Yes	Member Sex
12	Yes	Admission date
13	Yes	Admission Hour
14	Yes	Admission Type
15	Yes	Admission Source
16	Yes	Discharge Hour
17	Yes	Discharge Status
18-28	No	Condition Codes
29	No	ACDT States
30	No	Unassigned
31-34	No	Occurrence Code and Date
35-36	No	Occurrence Span
37	No	Untitled
38	No	Untitled

TABLE BLOCK #	REQUIRED?	DESCRIPTION
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)
45	Yes	Service Date
46	Yes	Units of Service
47	Yes	Total Charges
48	No	Non-Covered Charges
49	Yes	Modifier (if applicable)
50	No	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)

TABLE BLOCK #	REQUIRED?	DESCRIPTION
64	No	RecID Number for Resubmitting a Claim
65	No	Employer Name
66	No	Employer Location
67	Yes	Principal Diagnosis Code
68	No	A-Q Other Diagnosis
69	Yes	Admit Diagnosis
70	No	Patient Reason Diagnosis
71	No	PPS Code
72	No	ECI
73	No	Unassigned
74	No	Principal Procedure
75	No	Unassigned
76	Yes	Attending Physician NPI/TPI – First and Last Name and NPI
77	No	Operating Physician NPI/TPT
78-79	No	Other NPI
80	No	Remarks
81	No	Code-Code

PAPER RESUBMISSION

- See earlier table for an explanation of claim resubmission, when resubmission is appropriate, and procedural guidelines.
- If the resubmitted claim is received by Beacon later than allowed by the plan's filing limit (please refer to the health plan-specific contact information at the end of this manual for the plan's filing limit) 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 original claim number 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 original claim number corresponds with a single claim line on the Beacon EOB. Therefore, if a claim has multiple lines, there will be multiple original claim number 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 the plan's filing limit from the date on the EOB. Please refer to the health plan-specific contact information at the end of this manual for the plan's filing limit.

Paper Request for Adjustment or Void

- See earlier table for an explanation of adjustments and voids, when these requests are applicable, and procedural guidelines.
- Submit a corrected claim, with all required elements
- Place the original Claim Number in box 19 of the CMS 1500 claim form, or box 64 of the UB04 form
- Send the corrected claim to the address listed in the health plan-specific Contact Information sheet at the end of this manual.

4.4. Additional Claims Information/Requirements

CHANGE OF CLAIMS FILING ADDRESS

In the event that Beacon delegates, or employs another claims processing company, or changes the claim filing address, Beacon will provide the plan/state-required written notice to all in-network providers of such a change. Please refer to the health plan-specific contact information at the end of this manual for the plan/state required notice.

CATASTROPHIC EVENT

In the event that the carrier or provider is unable to meet the regulatory deadlines due to a catastrophic event, then the entity must notify your health plan within five days of the event. Within 10 days after return to normal business operations, the entity must provide a certification in the form of a sworn affidavit, which identifies the nature of the event, the length of interruption of claims submission or processing.

CLAIMS INQUIRIES AND RESOURCES

Additional information is available through the following resources:

Online

- Beacon 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

Beacon Main Telephone Numbers:

Beacon Health Options……855.371.9228

Main fax number……781.994.7600

TTY Number (for hearing impaired)……866.727.9441

Provider Relations……855.371.9228

Provider Relations fax……781.994.7639

Credentialing fax……781.994.7667

Provider Relations email:…… provider.relations@beaconhealthoptions.com

Claims Hotline……888.249.0478

eServices Helpline……866.206.6120

4.5. 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 and ensure proper billing practices within Beacon's documented guidelines.

Beacon's goal in this outreach program is to assist providers in as many ways as possible to receive payment in full, based upon contracted rates, for all services delivered to members. A provider may submit an administrative appeal, when Beacon denies payment based on the provider's failure to following administrative procedures for authorization. (Note that the provider may not bill the member for any services denied on this basis.)

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 COO and billing director, at the facility that Beacon has on file at the time of the report, as well as a copy of the report indicating the top denial reasons. A contact name is given for any questions or to request further assistance or training.

Complaints and Grievances

- Providers with complaints/grievances or concerns should contact their Beacon-contracted office and ask to speak with the clinical manager for the plan. All provider complaints are thoroughly researched by Beacon and resolutions proposed within 30 business days.
- If a plan member complains or expresses concerns regarding Beacon's procedures or services, health plan procedures, covered benefits or services, or any aspect of the member's care received from providers, he or she should be directed to call Beacon's Ombudsperson who is associated with that particular health plan. Please refer to the health plan-specific addendum for contact information.
- A complaint/grievance is any expression of dissatisfaction by a member, member representative, or provider about any action or inaction by Beacon other than an adverse action. Possible subjects for complaints/grievances include, but are not limited to, quality of care or services provided; Beacon's procedures (e.g., utilization review, claims processing); Beacon's network of behavioral health services; member billing; aspects of interpersonal relationships, such as rudeness of a provider or employee of Beacon; or failure to respect the member's rights.
- Beacon reviews and provides a timely response and resolution of all complaint/grievances that are submitted by members, authorized member representative (AMR), and/or providers. Every complaint/grievance is thoroughly investigated, and receives fair consideration and timely determination.
- Providers may register their own complaints/grievances and may also register complaints/grievances on a member's behalf. Members, or their guardian or representative on the member's behalf, may also register complaints/grievances. Contact us to register a complaint/grievance.
- If the complaint/grievance is determined to be urgent, the resolution is communicated to the member and/or provider verbally within 24 hours, and then in writing within 30 calendar days of receipt of the complaint/grievance. If the complaint/grievance is determined to be non-urgent, Beacon's ombudsperson will notify the person who filed the complaint/grievance of the disposition of his/her complaint/grievance in writing, within 30 calendar days of receipt.
- For both urgent and non-urgent complaints/grievances, the resolution letter informs the member or member's representative to contact Beacon's ombudsperson in the event that he/she is dissatisfied with Beacon's resolution.
- Member and provider concerns about a denial of requested clinical service, adverse utilization management decision, or an adverse action, are not handled as grievances. (See UM Reconsiderations and Appeals).

Appeals of Complaint/Grievance Resolutions

- If the member or member representative is not satisfied or does not agree with Beacon's complaint/grievance resolution, he/she has the option of requesting an appeal with Beacon.

- The member or member representative has 30-60 calendar days [depending on state regulation] after receipt of notice of the resolution to file a written or verbal appeal.
- Appeals of complaint/grievance resolutions are reviewed by Beacon's Peer Review Committee and assigned to an account manager from another health plan to review and make a determination. This determination will be made in a time frame that accommodates the urgency of the situation but no more than 10 business days. Notification of the appeal resolution will be telephonic on the same day of the resolution for urgent complaints/grievances. Written notification will be made within one to two business days of the appeal decision (time frames according to state regulation).

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.
- 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 XI3, 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.

RECOUPMENTS AND ADJUSTMENTS BY BEACON

Beacon reserves the right to recoup money from providers due to errors in billing and/or payment, at any time. In that event, Beacon applies all recoupments and adjustments to future claims processed, and report such recoupments and adjustments on the EOB with Beacon's Claim number and the provider's patient account number.

LIMITED USE OF INFORMATION

All information supplied by Beacon Health Options 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.

4.6. 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 claims submissions; this includes HIPAA-compliant revenue, CPT, HCPCS and ICD-10 codes. Providers should refer to their exhibit A for a complete listing of contracted, reimbursable procedure codes.
- Beacon accepts only ICD-10 diagnosis codes listing approved by CMS and HIPAA. In order to be considered for payment by Beacon, all claims must have a Primary ICD-10 diagnosis in the range of F01–F99. All diagnosis codes submitted on a claim form must be a complete diagnosis code with appropriate check digits.
- Claims for inpatient and institutional services must include the appropriate discharge status code. The table below lists HIPAA-compliant discharge status codes.

CODE	DESCRIPTION
01	Discharged to Home/Self-Care
02	Discharged/Transferred to a Short-Term General Hospital for Inpatient Care
03	Discharged/Transferred to Skilled Nursing Facility
04	Discharged/Transferred to Intermediate Care Facility
05	Discharged/Transferred to a Designated Cancer Center or Children's Hospital
06	Discharged/Transferred to Home/Home Health Agency
07	Left Against Medical Advice or Discontinued Care
09	Admitted as Inpatient to this Hospital
20	Expired
30	Still a Patient

BILL TYPE CODES

All UB04 claims must include the 3-digit bill type codes.

TYPE OF FACILITY 1ST DIGIT	
Hospital	1
Skilled Nursing	2
Home Health	3
Religious Non-Medical	4
Reserved for National Assignment	5

TYPE OF FACILITY 1ST DIGIT	
Intermediate Care	6
Clinic	7
Specialty Facility	8
Reserved for National Use	9

BILL CLASSIFICATION (EXCEPT CLINICS AND SPECIAL FACILITIES) 2ND DIGIT	
Inpatient (including Medicare Part A)	1
Inpatient (Medicare Part B Only)	2
Outpatient	3
Diagnostic Services	4
Intermediate Care – Level I	5
Intermediate Care – Level II	6
Reserved for National Assignment	7
Swing Bed	8
Reserved for National Use	9

BILL CLASSIFICATION (CLINICS ONLY) 2ND DIGIT	
Rural Health	1
Hospital Based or Independent Renal Dialysis Center	2
Freestanding	3
Outpatient Rehabilitation Facility (ORF)	4
Comprehensive Outpatient Rehabilitation Facilities (CORFS)	5
Community Mental Health Center	6

Reserved for National Use	7-8
Other	9

BILL CLASSIFICATION (SPECIAL FACILITIES ONLY) 2ND DIGIT	
Hospice (Non-Hospital Based)	1
Hospice (Hospital Based)	2
Ambulatory Surgery Center	3
Freestanding Birthing Center	4
Rural Primary Care Hospital	5
Reserved for National Use	6-8
Other	9

FREQUENCY 3RD DIGIT	
Non-Payment/Zero Claim	0
Admit Through Discharge	1
Interim, First Claim	2
Interim, Continuing Claim	3
Interim, Last Claim	4
Late Charge(s) Only Claim	5
Replacement of Prior Claim	7
Void/Cancel of Prior Claim	8
Reserved for National Assignment	9

OTHER BILL TYPES

77X – Federally Qualified Health Centers

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. Please see your specific contract for the list of contracted modifiers.

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.

ELECTRONIC FUNDS TRANSFER (EFT) AND ELECTRONIC REMITTANCE ADVICE (ERA)

- Beacon participates with PaySpan Health to administer EFT and to issue paper checks. Provider may choose either method of payment, but we encourage you to take advantage of EFT.
- EFT/ERA is safe, secure, and efficient.
- EFT makes it easier to reconcile payments
- To become a user, please complete the enrollment process at www.PaySpanhealth.com. Follow the instructions to select EFT or paper checks as your preferred method.
- You can also call the PaySpan Health provider hotline at 877.331.7154 for assistance with registration.

4.7. Billing of Expanded Services

ASSERTIVE COMMUNITY TREATMENT (ACT)

ACT services are billed once per month using one rate code for the month's services. There are three types of monthly payments which are dependent on the number and type of contacts with the recipient or collaterals: full, partial or inpatient. Claims are submitted using the last day of the month in which the services were rendered as the date of service. A contact or Unit of Service is defined as a face-to-face interaction of at least 15 minutes duration where at least one ACT service is provided between an ACT team staff member and the recipient or collateral. Providers should use the per diem code, with number of contacts during month in the unit field.

ACT services should be billed on an 837-I.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIERS	UNITS OF SERVICE
4508	ACT Intensive Full Payment	H0040	ACT per diem	None	6+
4509	ACT Intensive Part Payment	H0040	ACT per diem	U5	2-5
4511	ACT Inpatient	H0040	ACT per diem	U1, U5	2+

OMH-LICENSED CLINIC, OASAS-CERTIFIED CLINIC, OASAS-CERTIFIED OPIATE TREATMENT CLINIC, AND OASAS CERTIFIED OUTPATIENT REHABILITATION

OMH Clinics, both hospital-based and free-standing, will continue to bill with APG methodology using rate code, procedure code, and modifier code combinations in place since September 1, 2012.

OASAS-Certified Clinic

- OASAS Outpatient Programs
- OASAS-Certified Opiate Treatment Clinic
- OASAS Certified Outpatient Rehabilitation

OUTPATIENT PROGRAMS

Outpatient services are professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized non-residential treatment setting. Outpatient services are organized activities which may be delivered in any appropriate community setting that meets State licensure standards. All outpatient SUD programs are certified under OASAS Regulation in accordance with Mental Hygiene Law.

These services include, but are not limited to individual, group, family counseling including psycho education on recovery, and wellness. These programs offer comprehensive, coordinated, and defined services that may vary in level of intensity but are fewer than nine contact hours per week. New York State LOCADTR criteria are used to determine level of care In New York these are delivered in / by OASAS outpatient settings Certified by Title 14 NYCRR Part 822

OPIOID TREATMENT PROGRAMS (OTP)

OTPs are federally regulated programs that include direct administration of daily medication (opioid agonists: methadone or buprenorphine or antagonists following a successful agonist taper: naltrexone and vivitrol) as well as a highly structured psychosocial program that addresses major lifestyle, attitudinal, and behavioral issues that could undermine recovery-oriented goals. The participant does not have a prescription for the methadone or buprenorphine, but receives daily medication from the OTP. In New York Opioid Treatment Programs are certified by OASAS under Title 14 NYCRR Part 822.

OUTPATIENT REHABILITATION

Chemical dependence outpatient rehabilitation services (outpatient rehabilitation services) are services provided by an outpatient program which has been certified by OASAS to provide outpatient rehabilitation services; such services are designed to assist individuals with more chronic conditions who are typically scheduled to attend the outpatient rehabilitation program three to five days per week for at least four hours per day. (Part 822.15 (i)) outpatient rehabilitation services for individuals with more chronic conditions emphasize development of basic skills in prevocational and vocational competencies, personal care, nutrition, and community competency. These services are provided in combination with all other clinical services provided by outpatient programs. If an outpatient program is providing outpatient rehabilitation services, the following services must be available either directly or through written agreements: (1) socialization development; (2) skill development in accessing community services; (3) activity therapies; and (4) information and education about nutritional requirements, including but not limited to planning, food purchasing, preparation and clean-up. (e) A provider of outpatient rehabilitation services must assure the availability of one meal to each patient who receives outpatient rehabilitation services for four or more hours per day (Part 822.15 (a) (d) (e). In New York these are delivered in OASAS outpatient settings Certified by Title 14 NYCRR Part 822.

OASAS RATE CODES

Providers will input the rate code in the header of the claim as a value code. This is done in the value code field by first typing in "24" and following that immediately with the appropriate four digit rate code. This is the standard mechanism currently used in Medicaid FFS billing.

Rate Codes: Once the claim is received the plan will utilize the rate code for MEDS reporting. Rate codes are assigned based upon Certification/Program type and setting (hospital vs freestanding).

CODE TABLE	RATE CODE (SAME AS APG RATE CODE)
Title 14 NYCRR Part 822 Hospital Based OASAS Certified Outpatient	
Part 822 Hospital (Art 28 and Art 32) Chemical Dependence Outpatient Clinic Program	1528
Part 822 Hospital (Art 28 and Art 32) Chemical Dependence Outpatient Rehab Program (to be added to grouper at a later date)	1561
Part 822 Hospital (Art 28 and Art 32) Opiate Treatment Program	1567
Medical Services	
Part 822 Hospital (Art 28/ 32) Chemical Dependence Outpatient Program	1552
Part 822 Hospital (Art 28/32) Chemical Dependence Outpatient Rehab Program (to be added to grouper at a later date)	1558
Part 822 Hospital (Art 28/32) Opiate Treatment Program	1555
Title 14 NYCRR Part 822 Community/Freestanding	
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Clinic Program	1540
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Rehab Program	1573
Part 822 Community (Art 32 only) Opiate Treatment Program	1564
Medical Services	
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Program	1468

CODE TABLE	RATE CODE (SAME AS APG RATE CODE)
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Rehab Program	1570
Part 822 Community (Art 28/32) Opiate Treatment Program	1471

CONTINUING DAY TREATMENT (CDT)

CDT services are billed on a daily basis. The rates of reimbursement are separated into three tiers:

1. 1-40 hours
2. 41-64 hours
3. 65+ hours

These three tiers span across two types of visits: full-day (four hours minimum) and half-day (two hours minimum). Tiers are determined by totaling the number of full-day and half-day regular visits, based on their hour equivalents. As the hours accumulate throughout the month, the provider will need to move from one tier to another to bill. Each subsequent tier has a decline in payment. Providers must keep track of the number of hours of service provision in order to know what rate code (tier) should be billed.

When the program hours of any single visit include more than one tier, the provider of service will be reimbursed at the tier that applies to the first hour of that visit. Each CDT service tier has a unique combination of rate code/procedure code/modifier code(s), as indicated on the crosswalk below.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIERS	UNITS OF SERVICE
4310	CDT Half Day 1-40	H2012	Behavioral Health Day Treatment, per hour	U1, U5	2-3
4311	CDT Half Day 41-64	H2012	Behavioral Health Day Treatment, per hour	U2, U5	2-3
4312	CDT Half Day 65+	H2012	Behavioral Health Day Treatment, per hour	U3, U5	2-3
4316	CDT Full Day 1-40	H2012	Behavioral Health Day Treatment, per hour	U1	4-5
4317	CDT Full Day 41-64	H2012	Behavioral Health Day Treatment, per hour	U2	4-5

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIERS	UNITS OF SERVICE
4318	CDT Full Day 65+	H2012	Behavioral Health Day Treatment, per hour	U3	4-5
4325	CDT Collateral	H2012	Behavioral Health Day Treatment, per hour	UK	1
4331	CDT Group Collateral	H2012	Behavioral Health Day Treatment, per hour	UK, HQ	1
4337	CDT Crisis	H2012	Behavioral Health Day Treatment, per hour	U8	1
4346	CDT Pre-Admission	H2012	Behavioral Health Day Treatment, per hour	U9	1

CPEP

CPEP is claimed on a daily basis. A patient may receive one brief or one full emergency visit service in one calendar day. If a patient receives one of each, the CPEP will receive reimbursement for the full emergency visit. A provider may be reimbursed for either one crisis outreach service or one interim crisis service and either one brief or one full emergency visit per recipient, per one calendar day. If more than one service is provided, then more than one claim must be submitted (one claim for each rate code). Each CPEP service has a combination of rate code/procedure code/modifier code indicated on the crosswalk below. CPEP does not require prior authorization and a patient should receive access to services immediately upon presentation at a service delivery site.

Claiming for Extended Observation Beds:

- Admission to the extended observation bed is, for billing purposes, the calendar day after the calendar day in which the full or brief visit is completed.
- The extended observation bed rate may only be claimed when a person has been held in the CPEP for more than 24 hours.
- A brief or full visit claim is submitted for the calendar day in which the visit is completed, and claims for the extended observation bed are submitted for each subsequent day, up to 72 hours from the patient's initial arrival in the CPEP
- If the patient is admitted to the psychiatric inpatient unit, the extended observation bed rate is not claimed. The psychiatric inpatient unit rate is claimed instead beginning on admission to the extended observation bed

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4007	Brief Evaluation	90791	Psych Dx Evaluation	HK, U5	1	Billed on a daily basis
4008	Full Evaluation	90791	Psych Evaluation	HK	1	Billed on a daily basis
4009	Crisis Outreach Visit	S9485	Crisis Intervention Mental Health Services, per diem	HK	1	These are services provided outside an ER setting. Code also pays in HCBS and APGs so use the HK modifier to differentiate the claim. Billed daily.
4010	Interim Crisis Visit	H0037	Community Psych Support Treatment Program, per diem	HK	1	These are services provided outside an ER setting. Code also pays in HCBS and APGs so use the HK modifier to differentiate the claim. Billed daily.
4049	Extended Observation					See Notes above

INTENSIVE PSYCHIATRIC REHABILITATION TREATMENT (IPRT)

An IPRT claim is submitted on a daily basis. The applicable rate code/procedure code/modifier codes combination is dependent on the number of hours of service in the day. The combinations are listed on the crosswalk below. Reimbursement is provided for service duration of at least one hour and not more than five hours per recipient, per day.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIERS	UNITS OF SERVICE
4364	IPRT 1 Hour	H2012	Behavioral Health Day Treatment, per hour	HK, U1	1
4365	IPRT 2 Hours	H2012	Behavioral Health Day Treatment, per hour	HK, U2	2
4366	IPRT 3 Hours	H2012	Behavioral Health Day Treatment, per hour	HK, U3	3
4367	IPRT 4 Hours	H2012	Behavioral Health Day Treatment, per hour	HK, U4	4
4368	IPRT 5 Hours	H2012	Behavioral Health Day Treatment, per hour	HK, U5	5

PARTIAL HOSPITALIZATION

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4356	Partial Group Collateral - 2 Hours	H0035	Mental Health Partial Hosp. Treatment under 24 Hours	U2, HQ, HR or HS	2	Billed daily. Code with 2 units. Use HQ (group) modifier. Also use HR or HS modifier (in addition to HQ and U2). This code does not pay in APGs.
4357	Partial Hospitalization Crisis – 1 Hour	S9484	Crisis Intervention per hour	HK, U1, [UA]	1	Pays in APGs. Use HK modifier to differentiate claim from clinic (APGs). Billed daily. Add the UA modifier if the

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
						service is a pre-admission.
4358	Partial Hospitalization Crisis – 2 Hours	S9484	Crisis Intervention per hour	HK, U2, [UA]	2	Pays in APGs. Use HK modifier to differentiate claim from clinic (APGs). Billed daily. Add the UA modifier if the service is a pre-admission.
4359	Partial Hospitalization Crisis – 3 Hours	S9484	Crisis Intervention per hour	HK, U3, [UA]	3	Pays in APGs. Use HK modifier to differentiate claim from clinic (APGs). Billed daily. Add the UA modifier if the service is a pre-admission.
4360	Partial Hospitalization Crisis – 4 Hours	S9484	Crisis Intervention per hour	HK, U4	4	Pays in APGs. Use HK modifier to differentiate claim from clinic (APGs). Billed daily.
4361	Partial Hospitalization Crisis – 5 Hours	S9484	Crisis Intervention per hour	HK, U5	5	Pays in APGs. Use HK modifier to differentiate claim. Billed daily.
4362	Partial Hospitalization Crisis – 6 Hours	S9484	Crisis Intervention per hour	HK, U6	6	Pays in APGs. Use HK modifier to differentiate claim from clinic (APGs). Billed daily.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4363	Partial Hospitalization Crisis – 7 Hours	S9484	Crisis Intervention per hour	HK, U7	7	Pays in APGs. Use HK modifier to differentiate claim from clinic (APGs). Billed daily.

PERSONALIZED RECOVERY OUTCOME SERVICES (PROS)

A comprehensive PROS program is reimbursed on a monthly case payment basis. PROS claims use the last day of the month as the date of service and that date represents all the days for that month. Therefore, all the line level dates of service must also be the last day of the month. Each unique procedure code / modifier code(s) combination should be recorded on its own claim, along with the corresponding units of service and the pre-managed care rate code in the header of the claim.

In addition to the monthly case payment, PROS providers are also reimbursed for three component add-ons: IR, ORS and Clinic Treatment services. Up to two component add-ons may be billed per individual, per month. **In no event will an ORS component add-on and an IR component add-on be billed in the same month for the same individual.** Component add-ons are not billed prior to the calendar month in which the individual is registered with the PROS program.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4510	PROS Preadmission	H0002	Behavioral Health Screening, Admission Eligibility	HE	1	Billed monthly. The PROS units for the month are determined by using the "PROS Unit Conversion Chart" on a daily basis and then totaling for the month. Use the per diem code and show total PROS units for the month. The number of units coded does not affect payment, as payment is the

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
						same throughout the range.
4520	PROS Community Rehab Services, 2-12 units	H2019	Ther Behav Service, per 15 min	U1	2-12	Billed monthly. The PROS units for the month are determined by using the "PROS Unit Conversion Chart" on a daily basis and then totaling for the month. Use the per diem code and show total PROS units for the month. The number of units coded does not affect payment, as payment is the same throughout the range.
4521	PROS Community Rehab Services, 13-27 units	H2019	Ther Behav Service, per 15 min	U2	13-27	Billed monthly. The PROS units for the month are determined by using the "PROS Unit Conversion Chart" on a daily basis and then totaling for the month. Use the per diem code and show total PROS units for the month. The number of units coded does not affect payment, as payment is the

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
						same throughout the range.
4522	PROS Community Rehab Services, 28-43 units	H2019	Ther Behav Service, per 15 min	U3	28-43	Billed monthly. Requires at least 2 units of PROS in the CRS base (billed on separate line using H2019 - and showing total PROS units for the month). The two "base" units could include CRS, Clinic, Intensive Rehab, or ORS. Show only 1 unit on this line.
4523	PROS Community Rehab Services, 44-60 units	H2019	Ther Behav Service, per 15 min	U4	44-60	Billed monthly. Requires at least 6 units of PROS in the CRS base (billed on separate line using H2019 - and showing total PROS units for the month). These two "base" units could include CRS, Clinic, Intensive Rehab, or ORS. Show only 1 unit on this line.
4524	PROS Community Rehab	H2019	Ther Behav Service, per 15 min	U5	61+	Requires at least 2 units of PROS in the CRS base (billed on

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
	Services, 61+ units					separate line using H2019 - and showing total PROS units for the month). These two "base" units could include CRS, Clinic, IR, or ORS. Show only 1 unit on this line.
4525	PROS Clinical Treatment Add-on	T1015	Clinic Visit/Encounter, All Inclusive	HE	1	Billed monthly. Used instead of rate code 4510, but only for the BIP population. Limited to 4 (instead of only 2) consecutive months. Cannot be billed in same month as PROS monthly base rate services code or other PROS rate codes. This code pays in APGs. Use HE modifier to differentiate claim from clinic (APGs).
4526	PROS Int. Rehab	H2018	PsySoc Rehab Service, per diem	HE	1	This is a monthly add-on to the base rate and can be billed in combination with other add-ons. Two or three services are required (see

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
						billing manual), but use one (1) as the billing unit.
4534	Intensive Rehab - AH/NH/PC	H2018	PsySoc Rehab Service, per diem	UB, HE	1	This code is used in place of 4526 for the BIP population. The billing requirements are the same as 4526, but also include the UB modifier.

OASAS RESIDENTIAL TREATMENT

This setting provides medical and clinical services including: medical evaluation, ongoing medication management and limited medical intervention, ancillary withdrawal and medication assisted substance use treatment, psychiatric evaluation and ongoing management, group, individual and family counseling focused on stabilizing the patient and increasing coping skills until the patient is able to manage feelings, urges and craving, co-occurring psychiatric symptoms and medical conditions within the safety of the residence. All programs are certified under OASAS regulation Title 14 NYCRR Part 820 Part in accordance with Art 32 of the New York State mental hygiene law. Patients should receive an appointment immediately for inpatient substance use detoxification and within 24 hours for inpatient rehabilitation services, stabilization treatment services, substance use disorder outpatient and opioid treatment programs.

REHABILITATION SERVICES IN A RESIDENTIAL SETTING

In this setting medical staff is available in the residence however, it is not staffed with 24 hour medical/nursing services. This setting provides medical and clinical services including: medical evaluation, ongoing medication management and limited medical intervention, medication assisted substance use treatment when medically necessary, psychiatric evaluation and ongoing management, group, individual and family counseling focused on rehabilitation and increasing coping skills until the patient is able to manage feelings, urges and craving, co-occurring psychiatric symptoms and medical conditions within the community.

Treatment includes structured treatment including individual, group and family counseling. Programs are characterized by their reliance on the treatment community as a therapeutic agent. It is also to promote abstinence from substance use and interpersonal behaviors to effect a global change in participants' lifestyles, attitudes, and values. Individuals typically have multiple functional deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning, and disaffiliation from mainstream values. LOCADTR criteria are used to determine level of care.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
1144	Stabilization per diem	H2036	Alcohol and/or Other Drug Treatment Program, per diem	TG, HF	1 / day	Daily Per Diem associated with treatment services delivered to patients within an OASAS Certified Residential Stabilization Program. The per diem excludes room and board.
1145	Rehabilitation per diem	H2036	Alcohol and/or Other Drug Treatment program, per diem	HF	1 / day	Daily Per Diem associated with treatment services delivered to patients within an OASAS Certified Residential Rehabilitation Program. The per diem excludes room and board.
1146	Reintegration per diem	H2034	Alcohol and/or Drug Halfway House Services, per diem	HF	1 / day	Daily Per Diem associated with treatment services delivered to patients within an OASAS Certified Re-Integration Program. The per diem excludes room and board.

HARP HOME AND COMMUNITY BASED SERVICES (HCBS)

HCBS services are only available to HARP enrollees qualified through the assessment process and HARP eligible individuals enrolled in HIV-SNPs and assessed as HCBS eligible. A mainstream plan may provide HCBS to its enrollees as a cost effective alternative to regular OMH and OASAS licensed/certified

services (on an in lieu of basis and paid by the Mainstream plan from its capitation rate). A HARP may also make these service available to an otherwise unqualified individual on an in lieu of basis. In order to be reimbursable, services rendered, including scope and duration must be part of an approved personalized recovery plan.

Patient specific annual limitations exist for HCBS services. The proposed limits consist of three elements including:

- Patient-specific Tier 1 limit of $8,000. Tier I services include employment, education and peer supports services.
- Patient-specific overall HCBS (i.e., Tier 1 and Tier 2 combined) limit of $16,000
- Short-term crisis respite and intensive crisis respite are individually limited to 7 days per episode and 21 days per year.

When submitting claims for approved waiver program services:

- Claims should be submitted on a UB04 form or 837I file.
- Provider must enter a diagnosis code when submitting claims for all waiver services.
- Providers are required to use the most current, most specific diagnosis code when submitting their claims.

The table below provides a summary of billing for HCBS services.

RATE CODE	RATE CODE DESC.	PROC CODE	PROC. CODE DESC.	MOD.	UNIT MEAS.	UNITS LIMITS (Claim Line Level)	EDITS	NOTE	STAFF TRANSP.
TBD TBD	HCBS Eligibility Brief Assessment (by Health Home or arm's length entity under contract with HARP) (see note 1)	H0002	Behavioral health screening to determine eligibility for admission to treatment program	HH	None, code 1 unit	1	Maximum of three per year. Not to be billed on same day as full assess.	On-site or off-site. This code also pays in APGs so use HH modifier to differentiate the claim. This service is paid by the Health Plan, not Beacon.	Yes
TBD TBD	HCBS Full Assessment (by Health Home or arm's length entity under	H0031	Mental Health assessment, by non-physician	HH	None, code 1 unit	1	Maximum of two per year.	On-site or off-site. This code also pays in APGs so use HH modifier to	Yes

RATE CODE	RATE CODE DESC.	PROC CODE	PROC. CODE DESC.	MOD.	UNIT MEAS.	UNITS LIMITS (Claim Line Level)	EDITS	NOTE	STAFF TRANSP.
	contract with HARP)							differentiate the claim. This service is paid by the Health Plan, not Beacon.	
TBD	Psychosocial Rehabilitation - Per 15 Minutes (individual - on-site)	H2017	Psychosocial rehabilitation services; per 15 minutes	U1	Per 15 min	8	Cannot be billed on the same day as group or per diem PSR.	On-site rate code. Use U1 modifier.	No
TBD	Psychosocial Rehabilitation - Per 15 Minutes (individual - "one on one", off-site)	H2017	Psychosocial rehabilitation services; per 15 minutes	U2	Per 15 min	8	Cannot be billed on the same day as group or per diem PSR.	Off-site rate code. Use U2 modifier.	Yes
TBD	Psychosocial Rehabilitation - Per 15 Minutes (group of 2 or 3)	H2017	Psychosocial rehabilitation services; per 15 minutes	UN or UP	Per 15 min	4	Cannot be billed on the same day as per diem PSR service. Not billable with mileage based transportation	Mostly on-site. Use appropriate modifier.	No
TBD	Psychosocial Rehabilitation - Per 15 Minutes (group of 4 or 5)	H2017	Psychosocial rehabilitation services; per 15 minutes	UQ or UR	Per 15 min	4	Cannot be billed on the same day as per diem PSR service.	Mostly on-site. Use appropriate modifier.	No
TBD	Psychosocial Rehabilitation - Per 15 Minutes	H2017	Psychosocial rehabilitation services; per 15 minutes	US	Per 15 min	4	Cannot be billed on the same day as per diem PSR service.	Mostly on-site.	No

RATE CODE	RATE CODE DESC.	PROC CODE	PROC. CODE DESC.	MOD.	UNIT MEAS.	UNITS LIMITS (Claim Line Level)	EDITS	NOTE	STAFF TRANSP.
	(group of 6 or more)								
TBD	Psychosocial Rehabilitation - Per Diem (individual only - "one on one")	H2018	Psychosocial Rehabilitation ; per diem		Per diem	1	Cannot be billed on the same day as group or per 15 minute PSR.	On-site or off-site. Minimum of 3 hours.	Yes
TBD	Community Psychiatric Support and Treatment (physician)	H0036	Community Psychiatric Supportive Treatment, face-to-face; per 15 min	AF	Per 15 min	6		Off-site only. No groups.	Yes
TBD	Community Psychiatric Support and Treatment (NP, psychologist)	H0036	Community Psychiatric Supportive Treatment, face-to-face; per 15 min	SA or AH	Per 15 min	6		Off-site only. No groups.	Yes
TBD	Community Psychiatric Support and Treatment (RN, LMHC, LMFT, LCSW, LMSW)	H0036	Community Psychiatric Supportive Treatment, face-to-face; per 15 min	TD or AJ	Per 15 min	6		Off-site only. No groups.	Yes
TBD	Community Psychiatric Support and Treatment (all other allowable professions)	H0036	Community Psychiatric Supportive Treatment, face-to-face; per 15 min		Per 15 min	6		Off-site only. . No groups.	Yes

RATE CODE	RATE CODE DESC.	PROC CODE	PROC. CODE DESC.	MOD.	UNIT MEAS.	UNITS LIMITS (Claim Line Level)	EDITS	NOTE	STAFF TRANSP.
TBD	Peer Supports - provided by credentialed staff	H0038	Self Help / Peer Services, per 15 minutes	HE or HF	Per 15 min	16		On-site or off-site. Use HE modifier for an "OMH service" or the HF modifier for an "OASAS service".	Yes
TBD	Habilitation / Residential Supports Services	T2017	Habilitation, residential - waiver, 15 minutes		Per 15 min	12		On-site or off-site.	Yes
TBD	Short-term Crisis Respite (in a dedicated facility)	H0045	Respite Care Services, not in the home; per diem	HK, U5	Per diem	1	Cannot be billed on same day as intensive crisis respite.	Limit - 7 days per stay, 21 days per year. Must have PA before stay exceeds 72 hours. Billed daily. Bill U5 - reduced services modifier and HK modifier.	No
TBD	Short-term Crisis Respite (in a non-dedicated facility, e.g., CR)	H0045	Respite Care Services, not in the home; per diem	HE, U5	Per diem	1	Cannot be billed on same day as intensive crisis respite.	Limit - 7 days per stay, 21 days per year. PA not applicable. Billed daily. Bill U5 - reduced services modifier and HK modifier. Do not bill for transportation.	No

RATE CODE	RATE CODE DESC.	PROC CODE	PROC. CODE DESC.	MOD.	UNIT MEAS.	UNITS LIMITS (Claim Line Level)	EDITS	NOTE	STAFF TRANSP.
TBD	Intensive Crisis Respite	H0045	Respite Care Services, not in the home; per diem	HK	Per diem	1		Limit - 7 days per stay, 21 days per year. Billed daily. Use HK modifier.	No
TBD	Family Support and Training	H2014	Skills training and development; per 15 minutes	HR or HS	Per 15 min	12		On-site or off-site.	Yes
TBD	Family Support and Training (group of 2 or 3)	H2014	Skills training and development; per 15 minutes	HR or HS, UN or UP	Per 15 min	12		On-site or off-site.	Yes
TBD	Pre-vocational	T2015	Habilitation prevocational , waiver; per hour		Per hour	2	Only one employment service per day.	Service must be one-to-one. Must comply with VP/IDEA restrictions.	Yes
TBD	Transitional Employment	T2019	Habilitation, supported employment, waiver; per 15 minutes		Per 15 min	12	Only one employment service per day.	Service must be one-to-one. Must comply with VP/IDEA restrictions.	Yes
TBD	Intensive Supported Employment	H2023	Supported Employment	TG	Per 15 min	12	Only one employment service per day.	Service must be one-to-one. Must comply with VP/IDEA restrictions.	Yes
TBD	On-going Supported Employment	H2025	Ongoing support to maintain employment, per 15 minutes		Per 15 min	12	Only one employment service per day.	Service must be one-to-one. Must comply with VP/IDEA restrictions.	Yes

RATE CODE	RATE CODE DESC.	PROC CODE	PROC. CODE DESC.	MOD.	UNIT MEAS.	UNITS LIMITS (Claim Line Level)	EDITS	NOTE	STAFF TRANSP.
TBD	Education Support Services	T2013	Habilitation educational, waiver		Per hour	2		Service must be one-to-one. Must comply with VP/IDEA restrictions.	Yes
TBD	Provider Travel Supplement (cost of staff travel to off-site service locations)	A0160	Non-emergency transportation : per mile - case worker or social worker		Per mile	60		Billing is at the recipient level. 56 cents (per Federal guidelines). Billed on a daily basis. See note 2.	
TBD	Provider Travel Supplement (cost of staff travel to off-site locations - by subway)	A0160	Non-emergency transportation : per mile - case worker or social worker	U1	Per round trip	31	1st of the month billing only.	Billing is at the recipient level. Bill monthly. Use first day of the month as the date of service.	

Chapter 5

Communicating with Beacon

5.1. Transactions and Communications with Beacon

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

5.2. Electronic Media

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

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

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

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

INTERACTIVE VOICE RECOGNITION (IVR)

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 the member's full name, Plan ID and date of birth, when verifying eligibility through eServices and through Beacon's IVR.

ELECTRONIC TRANSACTIONS AVAILABILITY (WHEN BEACON IS A CLAIMS PAYOR)

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	
View authorization status	Yes	Yes	
Update practice information	Yes	No	
Submit claims	Yes	No	Yes (HIPAA 837)
Upload EDI claims to Beacon and view EDI Upload history	Yes	No	Yes (HIPAA 837)
View claims status	Yes	No	Yes (HIPAA 835)
Print claims reports and graphs	Yes	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	Yes	No	
Access Beacon's level of care criteria and provider manual	Yes	No	

EMAIL

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

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

5.3. Communication of Member and Provider Information

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

Providers are required to develop policies and procedures to ensure the confidentiality of behavioral health and substance use information. Comprehensive policies must include initial and annual in-service education of staff/contractors, identification of staff allowed to access and limits of access, procedure to limit access to trained staff, protocol for secure storage, procedure for handling requests for behavioral health and substance use information, and protocols to protect patients from discrimination.

CONFIDENTIALITY OF HIV-RELATED INFORMATION

Healthcare providers are required to develop policies and procedures to assure confidentiality of HIV-related information. Policies and procedures must include:

- Initial and annual in-service education of staff and contractors
- Identification of staff allowed access and limits of access
- Procedures to limit access to trained staff (including contractors)
- Protocols for secure storage (including electronic storage)
- Procedures for handling requests for HIV-related information
- Protocols to protect persons with or suspected of having HIV infection from discrimination

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

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

Providers must have policies and procedures in place to address members who present for unscheduled non-urgent care with the goal of promoting member access to appropriate care.

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

REQUIRED NOTIFICATIONS

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

TYPE OF INFORMATION	METHOD OF NOTIFICATION	
	eSERVICES	EMAIL
General Practice Information		

TYPE OF INFORMATION	METHOD OF NOTIFICATION	
	eSERVICES	EMAIL
Change in address or telephone number of any service	Yes	Yes
Addition or departure of any professional staff	Yes	Yes
Change in linguistic capability, specialty, or program	Yes	Yes
Discontinuation of any covered services listed in Exhibit A of provider's PSA	Yes	Yes
Change in licensure or accreditation of provider or any of its professional staff	Yes	Yes
Appointment Access		
Change in licensure or accreditation of provider or any of its professional staff	Yes (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 ID number (as specified in the PSA, Beacon is not required to accept assignment of the PSA to another entity)	No	Yes
Adding a site, service, or program not previously included in the PSA, remember to specify: a. Location b. Capabilities of the new site, service, or program	No	Yes

5.4. Beacon 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.

5.5. Other Benefits Information

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

YOUR HEALTH PLAN MEMBER IDENTIFICATION CARDS

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

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

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

5.6. Member Eligibility Verification Tools

ONLINE	ELECTRONIC DATA INTERCHANGE (EDI)	VIA TELEPHONE
Beacon's (Amidacare, Affinity, MetroPlus) 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@beaconhs.com	888.210.2018 Beacon's Integrated Voice Recognition (IVR)
ValueOptions (Emblem and VNSNY)	Providers with EDI capability can use ProviderConnect. For more information, refer to http://www.valueoptions.com/providers/E-Commerce.htm or contact the EDI Help Desk at e-supportservices@valueoptions.com	888.247.9311 from 8 am – 6 pm EST

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

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

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

5.7. Provider Training

Beacon offers training to our provider network as part of the implementation process. These trainings are typically offered as online webinars, with a variety of dates to accommodate provider schedules. The focus of these trainings are to acclimate the provider to Beacon's network.

During the course of these trainings, providers will learn about Beacon's history and philosophy, requirements for maintaining network participation, level of care criteria, and plan specific models of care. Concrete focus is given to Beacon's online platform, eServices.

The eServices related training covers registration and account administration, member eligibility verification, clinical authorization submission, claims transactions and requirements. The provider training will also encompass EDI claim submissions that feature plan specific details, along with Electronic Funds Transfers. Providers will also be advised of paper claim submission requirements, timely filing limits, and appeals for reconsiderations. Training materials are able to be distributed after the sessions for those that either missed the training, or wish to have as a copy for a reference guide.

Chapter 6

Care 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 according to 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.

- 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.
- Characteristics of the local delivery system available to the member include aspects suchas 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 current medications, innovative community service programs and new approaches to provision of psychotherapy and 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 assessment data, 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* are subject 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* benefit plan (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 a Beacon *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 governed by *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 orinfirmity
- 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/participatingprovider*
- 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 at least 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) NationalCoverage Determinations (NCD) or Local Coverage Determinations (LCD) Criteria.

2. If no CMS criteria exists for Medicare members and for all non-Medicare members, identify relevantcustom 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 HealthCriteria 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:

- 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).
- Change Healthcare's InterQual Behavioral Health Criteria
- American Society of Addiction Medicine (ASAM) Criteria
- NYS LOCADTR 3.0 (Level of Care for Alcohol and Drug Treatment Referral)
- Custom criteria, including state or client specific levels of care
- 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 this time. 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 a portion of its members' medical records using the tool posted on the *Beacon website*. Questions were developed from the resources.

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

Clinical Care Manager Reviews

CCMs obtain clinical data from the *provider/participating provider* or designee relating to the need for care and treatment planning. The *CCM* evaluates this information and references applicable medical necessity criteria 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	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.
symptoms and the member's anticipated response to treatment ▪ Recommended discharge plan following end of requested service		

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 viaProviderConnect
- 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. Notespecific 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 withgetting an appointment within seven days, please contact Beacon.

Adverse Clinical Determination/Peer Review

If a case does not appear to meet *medical necessity* criteria at the requested *level of care*, the *CCM*

attempts to discuss the *member's* needs with the *provider/participating provider* and to work collaboratively with the *provider/participating provider* to find an appropriate alternative *level of care*. If no alternative is agreed upon, the *CCM* cannot deny a request for services. Requests that do not appear to meet *medical necessity* criteria or present quality of care issues are referred to a *peer reviewer* for second level review. It is important to note that only a Psychiatrist and for some levels of care, a doctoral level clinical psychologist *peer reviewer* can clinically deny a request for services.

The *peer reviewer* considers the available information and may elect to conduct a Peer-to-Peer Review, which involves a direct telephone conversation with the attending or primary *participating provider* to discuss the case. Through this communication, the *peer reviewer* may obtain clinical data that were not available to the *CCM* at the time of the review. This collegial clinical discussion allows the *peer reviewer* the opportunity to explore alternative treatment plans with the *provider/participating provider* and to gain insight into the attending provider's anticipated goals, interventions and timeframes. The *peer reviewer* may request more information from the *provider/participating provider* to support specific treatment protocols and ask about treatment alternatives.

When an adverse determination is made, the treating provider (and hospital, if applicable) is notified of the decision. In urgent care cases, notification will be given telephonically at the time of the determination. Written notification of an adverse determination is issued to the *member*, *member* representative, practitioner, and facility within decision timeframes.

If an adverse decision is rendered, the *provider/participating provider* has the right to speak with the *peer reviewer* who made the adverse determination by calling Beacon at the toll-free phone number of the *member's* plan. For substance use treatment, and treatment of minors, Beacon follows federal and state guidelines regarding release of information in determining the distribution of adverse determination letters.

All written or electronic adverse determination notices include:

a. The specific reason(s) for the determination not to certify

b. A statement that the clinical rationale, criteria, (or copy of the relevant medical necessity criteria), guidelines, or protocols used to make the decision will be provided, in writing, uponrequest

c. The right of the *provider/participating provider* to request a reconsideration within three business days of receipt of the notice when a *medical necessity* denial is issued without a peer-to-peer conversation having taken place, or when an administrative denial is issued because of the failure of a *provider/participating provider* to respond to a request for peer-to-peer conversation within a specified timeframe

d. Rights to and instructions for initiating an *appeal*, including the opportunity to request an *expedited appeal* if applicable for first level *appeals*, and information about the *appeal* process

e. The right to request an *appeal* verbally, in writing, or via fax transmission

f. The timeframe for requesting an *appeal*

g. The opportunity for the *member*, *provider/participating provider* to submit, for consideration as part of the *appeals* process, written comments, documents, records, and other information relating to the case

h. Information regarding the appeals process for urgent care including that expedited external review may occur concurrently

i. The *member's* right to bring a civil action under the Employer Retirement Income Security Act of 1974 (ERISA), when applicable

Telehealth

Beacon has adopted several guidelines with recommendations when telehealth is used:

- American Psychological Association (APA) Guidelines for the Practice of Telepsychology
- American Psychiatric Association (APA) and American Telemedicine Association (ATA) BestPractice in Videoconferencing-Based Telemental Health
- American Academy of Child & Adolescent Psychiatry (AACAP) Telepsychiatry Toolkit
- National Association of Social Workers (NASW), Association of Social Work Boards (ASWB),Council on Social Work Education (CSWE) and Clinical Social Work Association (CSWA) Standards for Technology in Social Work Practice

Providers/*participating providers* can reference the Telemental Health Guidelines for decision-making on the appropriateness of ATA located on under 'Clinical Practice Guidelines' on the *website*. *Participating providers* should contact Beacon for benefit coverage prior to providing this service.

Outpatient Services

Prior to beginning a course of outpatient treatment, providers/participating providers must verify member eligibility and obtain authorization or certification (where applicable).

For some Plans, members are allowed a specific set of initial therapy sessions without prior authorization. These sessions, called initial encounters (IEs), must be provided by contracted in-network providers and are subject to meeting medical necessity criteria.

Beacon's model is to count the initial IEs to the provider, not member. This means that if the member changes providers, the count of initial encounters restarts with the new provider. Initial encounters may also be refreshed when a member has a break in treatment of more than six months. These IEs are not renewed annually, rather are applied towards each member's episode of care with a provider. An episodeof care is defined as continuous treatment with no gap greater than six months. A member is considered new to outpatient treatment if the member has not been in outpatient treatment within the previous six- month period as a member. Each IE is counted as one regardless of session duration and the total can be reviewed through our provider portal

Refer to your *provider agreement* for specific information about procedure and revenue codes that can be used for billing. Providers will be asked a series of clinical questions to support medical necessity for the service requested. If sufficient information is provided to support the request, the service will be authorized. If additional information is needed, the provider will be prompted to contact Beacon via phoneto continue the request for authorization. While Beacon prefers providers to make requests electronically,Beacon will work with providers who have technical or staffing barriers to requesting authorizations in thisway.

Providers should request *authorization* or certification for outpatient services electronically through our provider portal if authorization is needed. If the electronic method is not available, providers/*participating providers* should submit a Beacon *Outpatient Review* or other state-required or approved *outpatient review* form (where applicable), or use the toll-free number for a telephonic review where applicable. In instances where a review does not meet medical necessity criteria and/or where questions arise as to elements of a treatment plan, the case file may be forwarded to a *Peer Advisor* for review.

Appeal of Adverse Determinations

When a *member* assigns *appeal* rights in writing to a *participating provider*, the *participating provider* may *appeal* on behalf of the *member,* an adverse determinations (denials) made by Beacon. *Participating providers* must inform the *member* of adverse determinations and any *appeal* rights of which the *participating provider* is made aware.

Member appeal rights are limited to those available under the *member's* benefit plan, and may involve one or more levels of *appeal*.

While the number of *appeals* available is determined by the *member's* benefit plan, the type of *appeal*, 'administrative' or 'clinical', is based on the nature of the adverse determination. The *member's* care circumstances at the time of the request for *appeal* determine the category of *appeal* as *urgent*, non- urgent, or retrospective. The *member* benefit plan and applicable state and/or federal laws and regulations determine the timing of the *appeal* as expedited, standard, or retrospective. For example, if a *provider*/*participating provider* files a Level I *appeal* on behalf of a *member* in *urgent* care, the *appeal* is processed as an *expedited appeal*, even if the *member* is discharged prior to the resolution of the *appeal*.

Unless otherwise provided for in the *member* benefit plan, government sponsored health benefit program, or applicable state or federal law or regulation, the *provider/participating provider* and/or the *member* (or the *member's* authorized representative), has the right to file or request:

- An initial (Level I) *appeal* of an adverse determination for up to 180 calendar days from receipt ofnotice of the adverse determination. Initial (Level I) *appeals* may be made verbally, in writing, or via fax transmission.
- A second level (Level II) *appeal* of an adverse determination for up to 90 calendar days from receipt of notice of the Level I *appeal* determination, in those instances where a second level orLevel II *appeal* is available to the *member*. Unless otherwise provided for or restricted under the*member* benefit plan, government sponsored health benefit program, or applicable state or federal law or regulation, second level (Level II) *appeals* may be made verbally, in writing, or viafax transmission.

Unless otherwise provided for or restricted under the *member* benefit plan, government sponsored health benefit program, or applicable state or federal law or regulation, second level (Level II) *appeals* may be made verbally, in writing, or via fax transmission.

The *member*, *member's* authorized representative, and/or the *provider*/*participating provider* may submit any information they feel is pertinent to the *appeal* request and all such information is considered in the *appeals* review, whether or not it was available to Beacon's reviewers during the initial determination.

The date of the request for a Level I or Level II *appeal* of the adverse determination is considered thedate and time the *appeal* request is received by Beacon.

When a *provider*/*participating provider*, *member* (or the *member's* authorized representative) requests an *appeal* of an adverse determination, the *provider*/*participating provider* may not bill or charge the *member* until all *appeals* available to the *member* have been exhausted by the *member*, and the *member* agrees in writing to pay for non-certified services.

Written notice of determinations for all Level I and Level II *appeals* of adverse determinations will be made to the *member* and the *provider*/*participating provider* where required by the *member* benefit plan, government sponsored health benefit program, and/or applicable state or federal laws or regulations.

Unless otherwise provided for in the *member* benefit plan, government sponsored health benefit program, or applicable state or federal law or regulation, the chart below sets out the turn-around-times for completion of adverse determination *appeals* conducted by Beacon.

Unless otherwise provided for in the *member* benefit plan, government sponsored health benefit program, or applicable state or federal law or regulation, no adverse determination may be appealed to court, arbitration or otherwise unless and until all available Beacon administrative appeals have been utilized and exhausted. Failure to timely request any available Beacon administrative appeal shall preclude a provider from challenging an adverse determination in court, arbitration or otherwise.

Standard Turnaround Times for *Appeal* Completion and Notice by Type of Care Request[5]

TYPE OF CARE REQUEST AT TIME APPEAL IS FILED	APPEAL TYPE (CLINICAL AND ADMINISTRATIVE)		
	EXPEDITED APPEAL	STANDARD APPEAL (LEVEL I OR II)	RETROSPECTIVE APPEAL (LEVEL I OR II)
Urgent	Within 72 hours of receipt of the appeal request **Notification**: Verbalnotice to *provider* within one calendar day of decision; written notice to the *provider* and the *member* within the decision timeframes	N/A	N/A
Non-Urgent (Standard)	N/A unless provider indicates that delay would impact the life or health of member, then process as urgent above	Within 15 calendar days of the receipt of the request for *appeal* **Notification:** Written notice to the *provider* and the *member* within the decision timeframe	N/A
Retrospective	N/A	N/A	30 calendar days from receipt of request for *appeal* **Notification:** Written notice to *provider* and *member* within decision timeframe

Lack of Information

No extensions are allowed for lack of information or for "reasons beyond the control of Beacon". If information submitted is incomplete, Beacon has the option of requesting the necessary information; however, the decision must still be made within the timeframe for making the *appeal* decision, or making the decision based on information on hand.

6.1. Care Management

Beacon's Intensive Care Management Program (ICM) is designed to ensure the coordination of care for children and adults at significant clinical risk due to behavioral health conditions and psychosocial factors. The program includes assessment, care planning, advocacy and linkage to necessary support and services. Individualized care plans are developed in collaboration with members and their healthcare teams aimed at improving a member's overall functioning. Beacon case management is provided by licensed behavioral health clinicians.

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

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

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

Members who do not meet criteria for ICM may be eligible for care coordination. Members identified for care coordination have some clinical indicators of potential risk due to barriers to services, concern related to adherence to treatment recommendations, new onset psychosocial stressors, and/or new onset of co-morbid medical issues that require brief targeted care management interventions.

Care coordination is a short-term intervention for members with potential risk due to barriers in services, poor transitional care, and/or co-morbid medical issues that require brief care management interventions.

ICM and care coordination are voluntary programs, and member consent is required for participation. For further information on how to refer a member to case management services, please refer to the health plan-specific Contact Information sheet.

Beacon staff are trained to additionally assess a members need and eligibility for Health Home case management. New York State's Health Home eligibility criteria is as follows:

- Medicaid eligible/active Medicaid
- Two or more chronic conditions
- One single qualifying condition of either HIV/AIDS or a Serious Mental Illness (SMI)

Qualifying chronic conditions are defined in the State Plan Amendment as any of those included in the "Major" categories of the 3MTM Clinical Risk Groups (CRGs). A table of qualifying conditions included in these categories has been compiled and is shown below. Substance use disorders (SUDS) are in the list of qualifying chronic conditions, but do not by themselves qualify an individual for Health Home services. Individuals with SUDS must have another chronic condition (chronic medical or mental health) to qualify. A chronic condition in the context of determining eligibility for Health Homes implies a health condition that requires ongoing monitoring and care. The condition should not be incidental to the care of the member, but have a significant impact on their health and well-being.

In addition to having a qualifying condition, an individual must be appropriate for Health Home services. Individuals who are Medicaid eligible and have active Medicaid and meet diagnostic eligibility criteria may not necessarily be appropriate for Health Home care management. Individuals that meet the eligibility criteria for Health Homes and manage their own care effectively, do not need the level of care management provided by Health Homes. An individual must be assessed and found to have significant behavioral, medical, or social risk factors to deem them appropriate for Health Home services. An assessment must be performed for all presumptively eligible individuals to evaluate whether the person has significant risk factors and is appropriate for referral to Health Home care management services.
Determinants of medical, behavioral, and/or social risk can include:

- Probable risk for adverse events (e.g., death, disability, inpatient or nursing home admission);
- Lack of or inadequate social/family/housing support;
- Lack of or inadequate connectivity with healthcare system;
- Non-adherence to treatments or medication(s) or difficulty managing medications;
- Recent release from incarceration or psychiatric hospitalization;
- Deficits in activities of daily living such as dressing or eating; and
- Learning or cognition issues.

For more information on determining eligibility for Health Home services, see http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_home_policy.htm

Chapter 7

Quality Management and Improvement Program

7.1. Quality Management/Improvement Program Overview

Beacon administers, on behalf of the partner 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.

PROGRAM PRINCIPLES

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

PROGRAM GOALS AND OBJECTIVES

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

7.2. Provider Role

Beacon employs a collaborative model of continuous quality improvement, in which provider and member participation is actively sought and encouraged. In signing the PSA, all providers agree to cooperate with Beacon and the partner health plan's QI initiatives. Beacon also requires each provider to have its own internal Quality 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 in an advisory capacity or in the Consumer Advisory Council should contact the Member Services Department.

7.3. 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; and
    - Communication with member PCPs, other behavioral health providers, government and community agencies
- Tracking of adverse incidents, complaints, grievances and appeals
- Other quality improvement activities

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

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

HARP COMMITTEE STRUCTURE

In addition, Beacon and its health partners maintain committees such as the Medicaid Behavioral Health HARP Quality Management (BHHQM) Subcommittee that provide oversight, guidance, and ongoing performance monitoring for the HARP and QHP products. The committee meets on a quarterly basis and includes participation of members, peers, peer specialists and provider representatives in an advisory capacity to inform the design and implementation of key quality, UM and clinical initiatives.

For questions on how to join and participate in our committees, please contact Beacon.

7.4. 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 access to the health plan member information should be directed to Bea- con's privacy officer, elaine.stone@beaconhs.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.

TREATMENT RECORD STANDARDS

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

Member Identification Information

The treatment record contains the following member information:

- Member name and health plan identification # on every page
- Member's address
- Employer or school
- Home and work telephone number
- 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 health 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 substance abuse is- sues with their parents.

- Signed document indicating review of patient's rights and responsibilities

Medication Information

The 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

The 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 Abuse Information

Documentation for any member 12 years and older of past and present use of the following:

- Cigarettes
- Alcohol, and illicit, prescribed, and over-the-counter drugs

Adolescent Depression Information

Documentation for any member 13-18 years screened for depression:

- If yes, was a suicide assessment conducted?
- Was the family involved with treatment?

ADHD Information

Documentation for members aged 6-12 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 DSM diagnosis that is consistent with the stated presenting problems, history, mental status evaluation, and/or other relevant assessment information

j. Diagnoses updated at least on a quarterly basis

Treatment Planning

The treatment record contains clear documentation of the following:

- Initial and updated treatment plans consistent with the member's diagnoses, goals and progress
- Objective and measurable goals with clearly defined time frames for achieving goals or resolving the identified problems
- Treatment interventions used and their consistency with stated treatment goals and objectives
- Member, family and/or guardian's involvement in treatment planning, treatment plan meetings and discharge planning
- Copy of Outpatient Review Form(s) submitted, if applicable

Treatment Documentation

The treatment record contains clear documentation of the following:

- Ongoing progress notes that document the member's progress towards goals, as well as his/her strengths and limitations in achieving said goals and objectives
- Referrals to diversionary levels of care and services if the member requires increased interventions resulting from homicidality, suicidality or the inability to function on a day-to-day basis
- Referrals and/or member participation in preventive and self-help services (e.g., stress management, relapse prevention, Alcoholics Anonymous, etc.) is included in the treatment

record.

- Member's response to medications and somatic therapies

Coordination and Continuity of Care

The treatment record contains clear documentation of the following:

- Documentation of communication and coordination among behavioral health providers, primary care physicians, ancillary providers, and healthcare facilities. (See Behavioral Health – PCP Communication Protocol, and the 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.

7.5. 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

7.6. Practice Guidelines and Evidence-Based Practices

Beacon supports the use of nationally-recognized and validated Clinical Practice Guidelines (CPGs) and other evidence-based practice (EBPs) to provide Beacon with a mechanism to ensure the highest quality care for members through use of acceptable standards of care, and to reduce undesirable variance in diagnosis and treatment by ensuring compliance with established guidelines.

The selection of particular guidelines and standards of practice allows Beacon to provide its network of practitioners and providers with:

- Widely accepted established methods of treatment with proven efficacy
- Scientifically based materials that reflect current national trends and updated research in treatment
- A mechanism to provide input into decisions regarding the content of clinical practice guidelines

An essential component of assessing the efficacy of the selected clinical practice guidelines is to monitor practitioner and provider adherence with these guidelines. Measuring the extent to which practitioners and providers are able to effectively implement evidence-based practices allows Beacon to identify opportunities for improvement in the selection of such clinical resources and to identify venues to educate providers about implementing clinically-proven standards of care.

The process for such assessing adherence to guideline standards is as follows:

1. Annually, three CPGs are selected for monitoring of practitioner/provider adherence and compliance. One of the three CPGs selected must address children and adolescents.
    a. For each CPG selected, there are two or more important aspects of care selected for monitoring.
    b. The annual assessment or practitioner/provider adherence includes but is not limited to chart

reviews and claims data. This assessment may be population or practice based.

c. Results are measured annually through analysis of performance against the measures adopted. These results are used by Beacon to identify opportunities for improvement.

d. Interventions are implemented to improve practitioner/provider performance and to continually improve the quality of care provider to members.

The guidelines that Beacon promulgates include:

- Depression: APA "Practice Guideline for the Treatment of Patients with Major Depressive Disorder" published in 2010
- ADHD: AACAP "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder" published in 2007, 2011
- Adolescent depression: AACAP "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorder" published in 2007
- Substance abuse: APA "Treatment of Patients with Substance Use Disorders" published in 2010
- Schizophrenia: APA "Practice Guideline for the Treatment of Patients with Schizophrenia" published in 2004, 2009
- Beacon also supports best practice in the identification, screening, treatment and referral of members who are experiencing First Episode Psychosis (FEP).

Note: The CPGs and EBPs supported by Beacon may be subject to change based on ongoing review of the literature. Updates to resources and tools will be posted on Beacon's website.

Beacon expects providers to be aware of CPGs when making treatment referrals to in-network services to ensure members are accessing appropriate levels of care to best meet their clinical needs.

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 at provider.relations@beaconhealthoptions.com.

7.7. Outcomes Measurement

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

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

An essential aspect of Beacon's contracts with its health plan partners and the State of New York OMH and OASAS is to report at least quarterly regarding provider performance deficiencies and corrective actions related to performance issues. In addition, Beacon partners with the health plans to report any serious or significant health and safety concerns to OMH and OASAS immediately upon discovery. Please see the section regarding reporting of Adverse Incidents and other reportable events for more information.

7.8. Communication between Outpatient Behavioral Health Providers and PCPs, Other Treaters

Outpatient behavioral health providers are expected to communicate with the member's PCP and other outpatient behavioral health providers if applicable, as follows:

- Notice of commencement of outpatient treatment within four visits or two weeks, whichever occurs first
- Updates at least quarterly during the course of treatment
- 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 to be found on the Beacon website, 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

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

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

Outpatient providers' compliance with communication standards is monitored through requests for authorization submitted by the provider, and through chart reviews.

7.9. Communication between Inpatient/ Diversionary Providers and PCPs, Other Outpatient Treaters

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:

- 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 dis- charge reviews and documented in Beacon's member record.

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.

Members who refuse treatment to the extent permitted by law must be informed of the medical consequences of that action prior to termination.

Routine outpatient behavioral health treatment by an out-of-network provider is not an authorized service covered by Beacon Health Strategies. In certain cases, an exception is made to the out-of-network benefit restriction. These situations include when the member is new to the plan and needs transitional visits for 30 days; when cultural or linguistic resources are not available within the network; or when Beacon is unable to meet timeliness standards or geographic standards within the network.

7.10. Reportable Incidents and Events

Beacon requires that all providers report adverse incidents, other reportable incidents and sentinel events involving the health plan members to Beacon as follows:

ADVERSE INCIDENTS

An adverse incident is an occurrence that represents actual or potential serious harm to the well-being of a health plan member who is currently receiving or has been recently discharged from behavioral health services.

SENTINEL EVENTS

A sentinel event is any adverse incident occurring within or outside of a facility that either results in death of the member or immediately jeopardizes the safety of a health plan member receiving services in any level of care. These include:

1. Medicolegal deaths: Any death required to be reported to the Medical Examiner or in which the Medical Examiner takes jurisdiction (i.e., unexplained or violent death)
2. Any abduction or absence without authorization (AWA) involving a member who is under the age of 18 or who was admitted or committed pursuant to state laws and who is at high risk of harm to self or others
3. Any serious injury resulting in hospitalization for medical treatment
    a. A serious injury is any injury that requires the individual to be transported to an acute care hospital for medical treatment and is subsequently medically admitted.
4. Any sexual assault or alleged sexual assault involving a member
5. Any medication error that requires medical attention beyond general first aid procedures
6. Any physical assault or alleged physical assault by a staff person against a member
7. Any unscheduled event that results in the evacuation of a program or facility whereby regular operations will not be in effect by the end of the business day and may result in the need for finding alternative placement options for members
8. Suicide attempt at a behavioral health facility resulting in serious injury requiring medical admission

OTHER REPORTABLE INCIDENTS

An “other reportable incident” is any incident that occurs within a provider site at any level of care, which does not immediately place a health plan member at risk but warrants serious concern.

1. Non-medicolegal deaths
2. Suicide attempt at a behavioral health facility not requiring medical admission
3. Any absence without authorization from a facility involving a member who does not meet the criteria for a sentinel event as described above
4. Any physical assault or alleged physical assault by or against a member that does not meet the criteria of a sentinel event
5. Any serious injury while in a 24-hour program requiring medical treatment, but not hospitalization.
    a. A serious injury is an injury that requires the individual to be transported to an acute care hospital for medical treatment and is not subsequently medically admitted.

6. Any unscheduled event that results in the temporary evacuation of a program or facility, such as a small fire that requires fire department response
7. Member fall unrelated to a physical altercation on a behavioral health unit
8. A medical event resulting in admission to a medical unit or facility
9. Any possession or use of contraband to include illegal or dangerous substances or tools (i.e., alcohol/drugs, weapons, or other non-permitted substances or tools)
10. Self-injurious behavior exhibited by a member while at a behavioral health facility
11. Illegal behavior exhibited by a member while at a behavioral health facility defined as illegal by state, federal or local law (i.e., selling illegal substances, prostitution, public nudity)

REPORTING METHOD

- Beacon's Clinical Department is available 24 hours a day.
- Providers must call, regardless of the hour, to report such incidents.
- Providers should direct all such reports to their Beacon clinical manager or UR clinician by phone.
- In addition, providers are required to fax a copy of the Adverse Incident Report Form (for adverse and other reportable incidents and sentinel events) to Beacon's Ombudsperson at 781.994.7500. All adverse incidents are forwarded to the health plan for notification as well.
- Incident and event reports should not be emailed unless the provider is using a secure messaging system.

7.11. Provider Responsibilities

MEMBERS DISCHARGED FROM INPATIENT PSYCHIATRIC FACILITIES

Beacon requires that all members receiving inpatient psychiatric services must be scheduled for out-patient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. Beacon providers will follow up with Medicaid members and attempt to reschedule missed appointments.

Providers should be prepared to present:

- All relevant information related to the nature of the incident
- The parties involved (names and telephone numbers)
- The member's current condition

PRIMARY CARE PROVIDERS

The primary care provider (PCP) is important in the way that the members receive their medical care.

The individual provider is ultimately responsible for accuracy and valid reporting of all claims submitted for payment. A provider utilizing the services of a billing agency must ensure through legal contract (a copy of which must be made available to Beacon upon request) the responsibility of a billing service to

report claim information as directed by the provider in compliance with all policies stated by Beacon.

A member diagnosed as having a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time is eligible for a referral to a specialty care center and for a specialist to serve as the member's PCP.

PCPs also inform member of their rights to:

- Obtain complete and current information concerning a diagnosis, treatment, and prognosis in terms the member can be expected to understand. When it is not advisable to give such information to the member, the information is to be made available to an appropriate person acting on the member's behalf.
- Receive information as necessary to give informed consent prior to the start of any procedure or treatment
- Refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action

UPDATES TO CONTACT INFORMATION

It is important and required to contact Beacon in writing at the address listed on your Provider Service Agreement, where notices should be sent, or by email at provider.relations@beaconhealthoptions.com of any change of address, telephone number, group affiliation, etc.

Attachment 1

Ambulatory Mental Health Services for Adults

Attachment 1. Ambulatory mental health services for adults for which Mainstream Managed Care and Health and Recovery Plans may require prior and/or concurrent authorization of services.

Service	Prior Auth	Concurrent Review Auth	Additional Guidance
Outpatient mental health office and clinic services including: initial assessment; psychosocial assessment; and individual, family/collateral, and group psychotherapy	No	Yes	MMCOs/HARPs must pay for at least 30 visits per calendar year without requiring authorization. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law. Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCO/HARP; b) off-site clinic services; or c) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit (and must be delivered consistent with OMH clinic restructuring regulations: http://www.omh.ny.gov/omhweb/clinic_restructuring/part599/part-599.pdf)
Outpatient mental health office and clinic services: psychiatric assessment; medication treatment	No	Yes	
Outpatient mental health office and clinic services: off-site clinic services	Yes	Yes	OMH will issue further guidance regarding off-site clinic services.
Psychological or neuropsychological testing	Yes	N/A	
Personalized Recovery Oriented Services (PROS) Pre-Admission Status	No	No	Begins with initial visit and ends when Initial Service Recommendation (ISR) is submitted to Plan. Providers bill the monthly Pre-Admission rate but add-ons are not allowed. Pre-Admission is open-ended with no time limit.
PROS Admission: Individualized Recovery Planning	Yes	No	Admission begins when ISR is approved by Plan. Initial Individualized Recovery Plan (IRP) must be developed within 60 days of the admission date. Upon admission, providers may offer additional services and bill add-on rates accordingly for Clinical Treatment, Intensive Rehabilitation (IR), or Ongoing Rehabilitation and Supports (ORS). Prior authorization will ensure that individuals are not receiving duplicate services from other clinical or HCBS providers.
Mental Health Continuing Day Treatment (CDT)	Yes	Yes	
Mental Health Intensive Outpatient (note: Not State Plan)	Yes	Yes	
Mental Health Partial Hospitalization	Yes	Yes	
Assertive Community Treatment (ACT)	Yes	Yes	New ACT referrals must be made through local Single Point Of Access (SPOA) agencies. Plans will collaborate with SPOA agencies around determinations of eligibility and appropriateness for ACT following forthcoming NYS guidelines.

Service	Prior Auth	Concurrent Review Auth	Additional Guidance
OASAS-certified Part 822 clinic services, including off-site clinic services	No	Yes	See OASAS guidance regarding use of LOCATDR tool to inform level of care determinations. OASAS encourages plans to identify individual or program service patterns that fall outside of expected clinical practice but will not permit regular requests for treatment plan updates for otherwise routine outpatient and opioid service utilization; 30-50 visits per year are within an average expected frequency for OASAS clinic visits. The contractor will allow enrollees to make unlimited self-referrals for substance use disorder assessment from participating providers without requiring prior authorization or referral from the enrollee's primary care provider. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law.
Medically supervised outpatient substance withdrawal	No	Yes	Plans may require notification through a completed LOCADTR report for admissions to this service within a reasonable time frame.
OASAS Certified Part 822 Opioid Treatment Program (OTP) services	No	Yes	OASAS encourages plans to identify individual or program service patterns that fall outside of expected clinical practice but will not permit regular requests for treatment plan updates for otherwise routine outpatient and opioid service utilization; 150-200 visits per year are within an average expected frequency for opioid treatment clinic visits. The contractor will allow enrollees to make unlimited self-referrals for substance use disorder assessment from participating providers without requiring prior authorization or referral from the enrollee's primary care provider. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law.
OASAS Certified Part 822 Outpatient Rehabilitation	No	Yes	Plans may require notification through a completed LOCADTR report for admissions to this service within a reasonable time frame. The contractor will allow enrollees to make unlimited self-referrals for substance use disorder assessment from participating providers without requiring prior authorization or referral from the enrollee's primary care provider. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law.

Attachment 2

Beacon Health Strategies LLC/New York Level of Care Criteria

Beacon's Level of Care (LOC) criteria were developed from the comparison of national, scientific and evidence based criteria sets, including but not limited to those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA), Substance Abuse and Mental Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM). Beacon's LOC criteria, are reviewed and updated, at least annually, and as needed when new treatment applications and technologies are adopted as generally accepted medical practice.

Members must meet medical necessity criteria for a particular LOC. Medically necessary services are those which are:

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

B. Expected to improve an individual's condition or level of functioning.

C. Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs.

D. Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.

E. Reflective of a level of service that is safe, where no equally effective, more conservative, and less resource intensive treatment is available.

F. Not primarily intended for the convenience of the recipient, caretaker, or provider.

G. No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.

H. Not a substitute for non-treatment services addressing environmental factors.

Beacon uses its LOC criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths, and treatment history in determining the best placement for a member. Beacon's LOC criteria are applied to determine appropriate care for all members. In general, members will only be certified if they meet the specific medical necessity criteria for a particular LOC. However, the individual's needs and characteristics of the local service delivery system and social supports are taken into consideration.

In addition to meeting LOC criteria; services must be included in the member's benefit to be considered for coverage.

SECTION I: INPATIENT BEHAVIORAL HEALTH

This section contains information on LOC criteria and service descriptions for inpatient behavioral health treatment. Beacon's inpatient service rates are all inclusive with the single exception of electro-convulsive therapy (ECT). Routine medical care is also included in the per diem rate for inpatient treatment. Any medical care above and beyond routine must be reported to Beacon for coordination of benefits with the health plan.

A. Acute Inpatient Psychiatric Services

Acute inpatient psychiatric service is the most intensive level of psychiatric treatment, and it is used to stabilize individuals with an acute worsening, destabilization, or sudden onset psychiatric condition of short, severe duration. A structured treatment milieu and 24-hour medical and skilled nursing care is fundamental to inpatient treatment. Daily contact between the member and physician is required. Behavioral health providers may also have physical and mechanical restraint, isolation and locked units available as additional resources.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
Criteria # 1 - 4 must be met; For Eating Disorders, # 5 or 6 must also be met: 1. DSM or corresponding ICD diagnosis is present. 2. Member's psychiatric condition must require 24-hour medical/psychiatric and nursing services and/or must be of such intensity that needed services can only be provided by acute hospital care. 3. Inpatient services in an acute care hospital must be expected to significantly improve the member's psychiatric condition within a reasonable period of time so that acute, short-term 24-hour inpatient medical/psychiatric and nursing services will no longer be needed. 4. One of the following must also be present: a. Indication of actual and/or potential danger to self or others, such as serious suicidal ideation with plan and means available especially with a history of prior suicide attempts; b. History of suicidal ideation accompanied by severely depressed mood, significant losses and/or continuing intent to hurt self or others; c. Command hallucinations; d. Persecutory delusions;	**Criteria #1 - 6 must be met; For Eating Disorders, criterion #7 must be met:** 1. Member continues to meet admission criteria and another LOC is not appropriate. 2. Member is experiencing symptoms of such intensity that if discharged, s/he would likely need re-hospitalization; 3. Treatment is still necessary to reduce symptoms and improve functioning so member may be treated in a less restrictive LOC. 4. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 5. Family/guardian/caregiver is participating in treatment where appropriate, with documentation around coordination of treatment	**Criteria #1, 2, 3, or 4 are suitable; criteria # 5 and 6 are recommended, but optional. For Eating Disorders, criteria #7 - 9 must be met:** 1. Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive. 2. Member or parent/guardian withdraws consent for treatment and member does not meet criteria for involuntary/ mandated treatment. 3. Member does not appear to be participating in the treatment plan. 4. Member is not making progress toward goals, nor is there expectation of any progress. 5. Member's individual treatment plan and goals have been met. 6. Member's support system is aware and in agreement with the aftercare treatment plan.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
e. Documented history of violence; f. Loss of impulse control resulting in life threatening behavior, significant weight loss within the past three months, or self-mutilation that could lead to permanent disability; g. Homicidal ideation with indication of actual or potential danger to others; h. Indication of actual or potential danger to property evidenced by documented recent history of threats of violent or dangerous and destructive acts that may injure self or others i. Individual is impaired on the basis of their primary psychiatric illness to the degree that s/he manifests major disability in social, interpersonal, occupational and/or educational functioning and is not responsive to treatment and/or management efforts at a less intensive level of care; j. Individual has substance use disorder/dependence and need for treatment and services to ensure sobriety during stabilization of psychiatric condition; or k. Evidence of severe disorders of cognition, memory, or judgment not associated with a primary diagnosis of dementia or other cognitive disorder and family/community support cannot be relied upon to provide essential care. **For Eating Disorders:*** 5. Member has psychiatric, behavioral and general medical factors (such as a rapid or persistent decline in oral intake and significant decline in weight). 6. Member has had a rapid life threatening volitional weight (i.e. not	and with state agencies or other community agencies, if involved. 6. Coordination of care and active discharge planning are ongoing, with goal of transitioning the member to a less intensive LOC. **For Eating Disorders:** 7. No appreciable weight gain (<2lbs/wk) and/or unstable medical sequelae or refeeding complication	**For Eating Disorders:** 7. Member has reached at least 75% healthy body weight and has gained enough weight to achieve medical stability (e. g., vital signs, electrolytes, and electrocardiogram are stable). 8. No re-feeding is necessary 9. All other psychiatric disorders are stable.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
7. thought to be the result of medical illness loss (Body Mass Index <16) or below 75% of estimated healthy body weight that required treatment in an acute medical setting for one of the following: a. Marked physiological lability, e.g. significant postural hypotension, bradycardia, CHF, cardiac arrhythmia; b. Change in mental status; c. Body temperature below 96 degrees; d. Severe metabolic abnormality with anemia, hypokalemia, or other metabolic derangement; e. Acute gastrointestinal dysfunction such as esophageal tear from vomiting, mega colon or colonic damage from self-administered enemas; or f. Member has been uncooperative with treatment and/or is only able to cooperative in a highly structured, controlled setting that can provide one or all of the following: • Needed supervision during and after meals and/or required special feeding • Needed supervision during and after all meals and during use of bathroom **Exception to the above criteria may be made for early intervention with newly diagnosed adolescent anorexic admission requests.*		

B. Inpatient Substance Use Disorder Services - Medically Managed (Level IV Detoxification)

See ASAM Level 4 Criteria. For Medicaid, FIDA, and Dually Eligible members, please refer to the LOCATDR Criteria.

C. Acute Substance Use Disorders Treatment – Medically Monitored (Level III Detoxification)

See ASAM Level 4 Criteria or ASAM level 3.7 Criteria for Hudson. For Medicaid, FIDA, and Dually Eligible members, please refer to the LOCATDR Criteria.

D. Inpatient Acute Substance Disorder Rehabilitation (IP Rehab)

See ASAM Level 3.5 Criteria. For Medicaid, FIDA, and Dually Eligible members, please refer to the LOCATDR Criteria.

SECTION II: DIVERSIONARY SERVICES

Diversionary services are those mental health and substance use treatment services that are provided as clinically appropriate alternatives to behavioral health inpatient services, or to support a member in returning to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of diversionary services, those provided in a 24-hour facility, and those which are provided in a non-24-hour setting or facility.

This section contains service descriptions and level of care criteria for the following non-24-hour, diversionary services specifically designed to provide a continuum between inpatient and outpatient levels of care, including:

A. Acute Partial Hospital Programs (PHP)

B. Intensive Outpatient Programs (IOP); for substance use disorder LOC, see ASAM Criteria Level 2.1*

*For Medicaid, FIDA and Dually Eligible members, please refer to the LOCATDR Criteria.

C. Ambulatory Detoxification

D. Day Treatment

E. Continuing Day Treatment

F. Personalized Recovery Orientated Services (PROS)

G. Psychosocial Rehab (PSR)

H. Intensive Psychiatric Rehabilitation Treatment (IPRT)

I. Community Psychiatric Support and Treatment (CPST)

J. Assertive Community Treatment (ACT)

A. Acute Partial Hospital Programs (PHP)

Acute PHPs are short-term day programs consisting of intensive, acute treatment within a stable therapeutic milieu. These programs must be available at least five days per week, although seven-day availability is preferable. The short-term nature of an acute PHP makes it inappropriate for long-term day treatment. A PHP requires daily psychiatric management and active treatment comparable to that provided in an inpatient setting.
Length of stay generally ranges between two days to two weeks, and declines in intensity or frequency as an adult member establishes community supports and resumes normal daily activities or as a child or adolescent member returns to reliance on family, community supports and school. A PHP may be provided by either hospital-based or freestanding facilities for members experiencing symptoms of such intensity that they are unable to be safely treated in a less intense setting and would otherwise require admission to an inpatient LOC.

For children and adolescents who have a supportive environment to return to in the evening, a PHP provides services similar to a hospital level of care. As the youth decreases participation and returns to reliance on community supports and school, the PHP consults with the caretakers and the child's programs as needed to implement behavior plans, or participate in the monitoring or administration of medications.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
Criteria #1 - 8 must be met; For Eating Disorders, criterion #9 must also be met: 1. DSM or corresponding ICD diagnosis. 2. Member manifests significant or profound impairment in daily functioning due to psychiatric illness. 3. Member has adequate behavioral control and is assessed not to be an immediate danger to self or others and does not require 24-hour medical supervision. 4. Member has a community-based network of support and/or parents or caretakers who are able to ensure member's safety outside the treatment hours. 5. The member requires access to a structured treatment program with an on-site multidisciplinary team.	**Criteria # 1 - 6 must be met; For Eating Disorders, criterion # 7 must also be met:** 1. Member continues to meet admission criteria and another LOC is not appropriate. 2. Treatment is still necessary to reduce symptoms and increase functioning, so the member may be treated in a less intensive LOC. 3. Member's progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress toward a set of clearly defined and measurable goals. 4. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out.	**Criteria 1, 2, 3, or 4 are suitable; criteria # 5 and 6 are recommended, but optional; For Eating Disorders, criterion # 7 must also be met:** 1. Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive. 2. Member or parent/guardian withdraws consent for treatment. 3. Member does not appear to be participating in treatment plan. 4. Member is not making progress toward goals, nor is there expectation of any progress.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
6. Member can reliably attend and actively participate in all phases of the treatment program necessary to stabilize their condition. 7. The severity of the presenting symptoms is such that the member is unable to be treated safely or adequately in a less intense outpatient setting. 8. Member has fair to good motivation to recover in the structure of the ambulatory treatment program. **For Eating Disorders:** 9. Member requires admission to achieve at least one of the following: a. Stabilize weight and/or accomplish targeted weight gain; b. Reduction in compulsive exercising or repetitive behaviors that negatively impact daily functioning.	5. Family/guardian/caregiver is participating in treatment as clinically indicated and appropriate, or engagement efforts are underway. 6. Coordination of care and active discharge planning are ongoing, with goal of transitioning member to a less intensive LOC. **For Eating Disorders:** 7. Member has had no appreciable weight gain since admission.	5. Member's individual treatment plan and goals have been met. 6. Member's support systems are in agreement with the aftercare treatment plan. **For Eating Disorders:** 7. Member has been compliant with the eating disorder related protocols and can now be managed in a less intensive LOC.

B. Intensive Outpatient Programs (IOP) For SA LOC See ASAM Criteria Level 2.1. For Medicaid, FIDA and Dually Eligible members, please refer to the LOCATDR Criteria.

Intensive outpatient programs (IOP) are similar to partial hospital programs (PHP), offering short-term day or evening programming consisting of intensive treatment within a stable therapeutic milieu. These programs must be available at least five days per week, although seven-day availability is preferable. Participation should be a minimum of three times per week, increasing based on clinical need. Briefly tapering to fewer than three times per week while transitioning to less intensive services is appropriate when clinically indicated. IOPs are required to provide daily management and active treatment comparable to that provided by a PHP setting. Length of stay generally ranges from one to three weeks, declining in intensity as the member establishes community supports and resumes normal daily activities. The short-term nature of IOPs makes it inappropriate to meet the need for long-term day treatment. IOPs may be provided by either hospital-based or freestanding outpatient programs to members who are experiencing symptoms of such intensity that they are unable to be safely treated in a less intensive setting and would otherwise require admission to a more intensive LOC, e.g., PHP.

For youth, the IOP provides services similar to an acute LOC for those who have a supportive environment to return to in the evening. As the child decreases participation and returns to reliance on community supports and school, the IOP consults with the child's caretakers and other providers to implement behavior plans or participate in the monitoring or administration of medications.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
All of the following criteria must be met: 1. DSM or corresponding ICD diagnosis (excluding mental retardation or other developmental disorder diagnosis). 2. Member has adequate capacity to participate in and benefit from this treatment. 3. Member has significant impairment in daily functioning due to a psychiatric illness or substance use of such intensity that the member cannot be managed in a routine outpatient LOC. 4. Member is assessed to be at risk of requiring higher levels of care if not engaged in IOP treatment. 5. Member's living environment offers enough stability to support IOP treatment. 6. Member's biomedical condition and/or co-morbid substance use disorder is sufficiently stable to be managed in an outpatient setting.	**All of the following criteria must be met:** 1. Member continues to meet admission criteria and another LOC is not appropriate. 2. Member is experiencing symptoms of such intensity that if discharged, member would likely require a more intensive LOC. 3. Treatment is still necessary to reduce symptoms and improve functioning so the member may be treated at a less intensive LOC. 4. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 5. Member progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress toward a set of clearly defined and measurable goals. 6. Family/guardian/caregiver is participating in treatment as appropriate. Documentation reflects coordination of treatment with all involved parties including state and/or community agencies when appropriate.	**Criteria # 1, 2, 3, or 4 are suitable; criteria # 5 and 6 are recommended, but optional:** 1. Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive. 2. Member or guardian withdraws consent for treatment. 3. Member does not appear to be participating in the treatment plan. 4. Member is not making progress toward goals, nor is there expectation of any progress. 5. Member's individual treatment plan and goals have been met. 6. Member's support system is in agreement with the aftercare treatment plan.

C. Ambulatory Detoxification

See ASAM Level 1 Criteria. For Medicaid, FIDA, and Dually Eligible members, please refer to the LOCATDR Criteria.

D. Day Treatment

The goal of day treatment is to assist children, adolescent with psychiatric disorders plus either an extended impairment in functioning due to emotional disturbance or a current impairment in functioning with severe symptoms to improve functioning so that they can return to educational settings. Adolescents may continue to receive day treatment services over the age of 18, but under the age 22 if admission occurred prior to age of 18. Youngsters that benefit from behavioral health services that have significant challenges in educational settings would benefit from day treatment. Day treatment is focused on treatment services designed to stabilize the youth's adjustment to educational settings, to prepare children for return to education settings and assist with the transition.

Services include health referral, medication therapy, verbal therapy, crisis intervention, case management, social, task and skill training, and socialization.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
Criteria #1-7 must be met: 1. Member has an active DSM or corresponding ICD diagnosis (excluding mental retardation or other developmental disorders). 2. Member has an extended impairment in functioning due to emotional disturbance or a current impairment in functioning with severe symptoms. 3. Member has the capacity to participate and benefit from day treatment. 4. Treatment at a less intensive LOC would contribute to an exacerbation of symptoms. 5. The severity of presenting symptoms is such that member is unable to be adequately treated in a less intensive LOC.	**All of the following criteria must be met:** 1. Member continues to meet admission criteria; 2. Another less intensive LOC would not be adequate to administer care. 3. Treatment is still necessary to reduce symptoms and increase functioning for member to be treated at a less intensive LOC. 4. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 5. Family/guardian/caregiver is participating in treatment as clinically indicated and appropriate, or engagement efforts are underway. 6. Coordination of care and active discharge planning are ongoing, with goal of transitioning the member to a less intensive LOC.	**Criteria # 1, 2, 3, or 4 are suitable; criteria #5 and 6 are recommended, but optional:** 1. Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive. 2. Member or parent/guardian withdraws consent for treatment. 3. Member does not appear to be participating in treatment plan. 4. Member is not making progress toward goals, nor is their expectation of any progress. 5. Member's individual treatment plan and goals have been met. 6. Member's guardian in agreement with the aftercare treatment plan.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
6. Member requires individual intervention and/or part-time center based supervision for safety or to safely facilitate transition to a less intensive LOC. 7. Member's guardian is willing to participate in treatment, as appropriate.		

E. Continuing Day Treatment

Continuing day treatment (CDT) shall provide more intensive and rehabilitative treatment and services, which are designed to preserve or enhance an individual's recovery process for living, learning, working and socializing in his or her community of choice, and to develop self-awareness and self-esteem through the exploration and development of personal strengths and interests. A CDT program shall provide the following services: assessment and treatment planning, discharge planning, medication therapy, medication education, case management, health screening and referral, psychiatric rehabilitation readiness development, psychiatric rehabilitation readiness determination and referral and symptom management. The following additional services may also be provided: supportive skills training, activity and verbal therapy, and crisis intervention and clinical support services. Participants often attend several days per week with visits lasting more than an hour.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
All of the following criteria must be met: 1. The member has a DSM or ICD psychiatric diagnosis. 2. The member experiences significant impairment in his or her ability to live, learn, work or socialize in the community due to psychiatric illness. 3. The member exhibits adequate control over his or her behavior. The individual is assessed not to be an immediate danger to self or others and does not require 24-hour medical supervision.	**All of the following criteria must be met:** 1. The individual continues to meet admission criteria, and less intensive care is not appropriate. 2. Treatment is still necessary in order to reduce the individual's symptoms and increase his or her ability to live, learn, work or socialize in the community at a less restrictive level of care. 3. Medication trials have been attempted or ruled out, if appropriate.	**Criteria 1, 2, or 3 are present; Criteria 4 and 5 are recommended, but optional:** 1. The member no longer meets admission criteria and/or meets criteria for a different LOC, either more or less intensive. 2. The member withdraws consent for treatment and does not meet criteria for involuntary/mandated treatment. 3. The member does not appear to be participating in treatment plan, is not making progress toward goals, nor is

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
4. The member requires daily structure in order to foster retention and restoration of community living, socialization and adaptive skills. 5. The member has a community-based network of support that can assist them with living in the least restrictive environment. 6. The member has the capacity for reliable attendance, active participation and engagement in all phases of the program. 7. The severity of the presenting symptoms is such that the member is unable to be treated safely or adequately in a less intense outpatient setting. 8. The member demonstrates cognitive functioning and the potential for recovery-oriented goals.	4. The individual, family/guardian(s)/caregiver(s) are participating in treatment as clinically indicated and where appropriate, or engagement efforts are underway. 5. Coordination of care and active discharge planning has been initiated with a goal of transitioning the individual to a less intense LOC.	there expectation of making progress towards goals. 4. The member's recovery plan and goals have been met. 5. The member's support systems is aware and in agreement with the aftercare treatment plan.

F. Personalized Recovery Orientated Services (PROS)

PROS programs offer a customized array of recovery-oriented services, both in traditional program settings and in off-site locations where people live, learn, work or socialize. The purpose of PROS is to assist individuals in recovering from the disabling effects of mental illness through the coordinated delivery of rehabilitation, treatment and support services. Goals for members in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education, and secure preferred housing. There are four service components, including community rehabilitation and support (CRS), intensive rehabilitation (IR), ongoing rehabilitation and support (ORS), and clinical treatment.

Intensive Rehabilitation consists of four different services:

1. Intensive Rehabilitation Goal Acquisition
2. Intensive Relapse Prevention
3. Family Psychoeducation

4. Integrated Dual Disorder Treatment

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
All of the following criteria must be met: 1. The member has a designated mental illness diagnosis. 2. The member must be 18 years of age or older. 3. The member must be recommended for admission by a Licensed Practitioner of the Healing Arts. 4. The member exhibits functional deficits related to the severity and duration of a psychiatric illness in any of the following areas: self-care, activities of daily living, interpersonal relations, and/or adaptation to change or task performance in work or work-like settings. 5. Pre-Admission begins with initial visit and ends when Initial Service Plan (ISR) is submitted to MMCO/HARP. 6. Admission begins when ISR is approved by MMCO/HARP. IRP must be developed within 60 days of admission date. 7. Active Rehabilitation begins when the Individualized Recovery Plan (IRP) is approved by the MMCO/HARP and IRP indicates required services designed to engage and assist members in managing their illness and restoring those skills and supports necessary for living successful in the community.	**All of the following criteria must be met:** 1. The member continues to work towards goals, identified in an IRP. 2. Concurrent review and authorizations should occur at three-month intervals for IR, ORS, and CR services. Continuing stay criteria may include: a. The member has an active recovery goal and shows progress toward achieving it; b. The member has met and is sustaining a recovery goal, but, would like to pursue a new goal; c. The member requires a PROS level of care in order to maintain psychiatric stability and there is not a less restrictive level of care that is appropriate; OR without PROS services the individual would require a higher level of care. 3. A member is not receiving Home and Community Based Services other than peer support services, education support services and crisis residential services.	**Any one of the following must be met:** 1. The member has sustained recovery goals for six to 12 months and a lower LOC is clinically indicated. 2. The member has achieved current recovery goals and can identify no other goals that would require additional PROS services. 3. The member is not participating in a recovery plan and is not making progress toward any goals. Extensive engagement efforts have been exhausted, and there is insignificant expected benefit from continued participation. 4. The member can live, learn, work and socialize in the community with supports from natural and/or community resources.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
8. The individual has developed or is interested in developing a recovery/life role goal. 9. There is not a lower level of care which is more appropriate to assist member with recovery goals. 10. A member is not receiving Home and Community Based Services other than peer support services, education support services and crisis residential services.		

Ongoing Rehabilitation and Support (ORS) Criteria

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
One of the following criteria must be met: 1. Member has a specific goal related to employment. 2. Member would benefit from support in managing their symptoms in a competitive workplace. 3. A member is not receiving Home and Community Based Services other than peer support services, education support services and crisis residential services.	Member continues to meet one of the following: 1. Member continues to have a goal for competitive employment. 2. Member continues to benefit from supportive services in managing their symptoms in the competitive workplace. 3. A member is not receiving Home and Community Based Services other than peer support services, education support services and crisis residential services.	Any one of the following must be met: 1. The member no longer requires supportive services for managing symptoms in the competitive workplace. 2. The member no longer is seeking competitive employment. 3. The member has achieved current recovery goals and can identify no other goals that would require ongoing rehabilitation and support.

Intensive Rehabilitation (IR) Criteria

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
One of the following criteria must be met:	**Member continues to meet one of the following:**	**Any one of the following must be met:**

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
1. Member has a specific goal related to education, housing or employment in which short term, intensive rehabilitation services would assist in achieving goal within desired timeframe. 2. The member is experiencing psychosocial stressors and/or difficulty in symptom management that has increased risk for hospitalization, involvement in criminal justice system, loss of housing, or other identified issues in which community tenure is at risk. Member would benefit from intensive rehabilitation and recovery services for relapse prevention. 3. Family psychoeducation would benefit member in achieving life role goal and maintaining community tenure. 4. Member has a co-occurring substance use disorder (including tobacco dependence) and would benefit from Integrated Dual Treatment. 5. A member is not receiving Home and Community Based Services other than peer support services, education support services and crisis residential services.	1. Member has a specific goal related to education, housing or employment in which short term, intensive rehabilitation services would assist in achieving goal within desired timeframe. 2. The member is experiencing psychosocial stressors and/or difficulty in symptom management that has increased risk for hospitalization, involvement in criminal justice system, loss of housing, or other identified issues in which community tenure is at risk. Member would benefit from intensive rehabilitation and recovery services for relapse prevention. 3. Family psychoeducation would benefit member in achieving life role goal and maintaining community tenure. 4. Member has a co-occurring substance use disorder (including tobacco dependence) and would benefit from Integrated Dual Treatment. 5. A member is not receiving Home and Community Based Services other than peer support services, education support services and crisis residential services.	1. The member is no longer at risk of hospitalization, involvement in criminal justice system and community tenure is assured in which intensive rehabilitation is no longer required. 2. The member has achieved current recovery goals and can identify no other goals that would require intensive rehabilitation. 3. The member can live, learn, work and socialize in the community with supports from natural and/or community resources without intensive rehabilitation.

G. Psychosocial Rehab (PSR)

Psychosocial rehab services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their behavioral health condition (i.e., SUD and/or mental health). Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's recovery plan. The intent of PSR is to restore the individual's functional level to the fullest possible (i.e., enhancing SUD resilience factors) and as necessary for integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
All of the following criteria must be met: 1. DSM or corresponding ICD diagnosis 2. Member has adequate capacity to participate in and benefit from this treatment. 3. Member has significant impairment in daily functioning due to a psychiatric illness or substance use of such intensity that the member cannot be managed in a lower level of care 4. Member is assessed to be at risk of requiring higher levels of care if not engaged in PSR treatment. 5. An individual must have the desire and willingness to receive rehabilitation and recovery services as part of their individual recovery plan, with the goal of living their lives fully integrated in the community and, if applicable, to learn skills to support long-term recovery from substance use through independent living, social support, and improved social and emotional functioning.	**All of the following criteria must be met:** 1. The member continues to meet admission criteria 2. One of the following is present: a. The member has an active goal and shows progress toward achieving it. b. The member has met and is sustaining a recovery goal, but would like to pursue a new goal related to a functional deficit in one of the above areas. c. The member requires a PRS LOC in order to maintain psychiatric stability; there is not a less restrictive level of care that is appropriate or without PRS services; and the individual would require a higher level of care.	**Any one of the following must be met:** 1. The member no longer meets PRS LOC criteria. 2. The member has sustained recovery goals for three to six months and a lower level of care is clinically indicated. 3. The member has achieved current recovery goals and can identify no other goals that would require additional PSR services in order to achieve those goals. 4. The member is not participating in a recovery plan and is not making progress toward any goals. 5. Extensive engagement efforts have been exhausted and there is insignificant expected benefit from continued participation. 6. The member can live, learn, work and socialize in the community with supports from natural and/or community resources.

H. Intensive Psychiatric Rehabilitation Treatment Programs (IPRT)

An IPRT program is time-limited with active psychiatric rehabilitation designed to assist an individual in forming and achieving mutually agreed upon goals in living, learning, working and social environments; to intervene with psychiatric rehabilitation technologies, to overcome functional disabilities from mental illness and to improve environmental supports. IPRT programs shall provide the following services: psychiatric rehabilitation readiness determination, psychiatric rehabilitation goal setting, psychiatric rehabilitation functional and resource assessment, psychiatric rehabilitation service planning, psychiatric rehabilitation skills and resource development, and discharge planning.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
All of the following criteria must be met: 1. DSM or corresponding ICD diagnosis 2. Member has adequate capacity to participate in and benefit from this treatment. 3. Member has significant impairment in daily functioning due to a psychiatric illness or substance use of such intensity that the member cannot be managed in a lower level of care 4. Member is assessed to be at risk of requiring higher levels of care if not engaged in IPRT treatment.	**All of the following criteria must be met:** 1. The member continues to meet admission criteria 2. One of the following is present: a. The member has an active goal and shows progress toward achieving it. b. The member has met and is sustaining a recovery goal, but would like to pursue a new goal related to a functional deficit in one of the above areas. c. The member requires an IPRT LOC in order to maintain psychiatric stability; there is not a less restrictive level of care that is appropriate or without IPRT services; and the individual would require a higher level of care.	**Any one of the following must be met:** 1. The member no longer meets PRS LOC criteria. 2. The member has sustained recovery goals for three to six months and a lower level of care is clinically indicated. 3. The member has achieved current recovery goals and can identify no other goals that would require additional IPRT services in order to achieve those goals. 4. The member is not participating in a recovery plan and is not making progress toward any goals. 5. Extensive engagement efforts have been exhausted and there is insignificant expected benefit from continued participation. 6. The member can live, learn, work and socialize in the community with supports from natural and/or community resources.

I. Community Psychiatric Support & Treatment (CPST)

Community psychiatric support & treatment (CPST) includes time-limited goal directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the individual's Plan of Care and CPST Individual Recovery Plan. The following activities under CPST are designed to help persons with serious mental illness to achieve stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. CPST is designed to provide mobile treatment and rehabilitation services to individuals who have difficulty engaging in site-based programs who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family of choice in their treatment.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
All of the following criteria must be met: 1. DSM or corresponding ICD diagnosis 2. Member has adequate capacity to participate in and benefit from this treatment. 3. Member has significant impairment in daily functioning due to a psychiatric illness or substance use of such intensity that the member cannot be managed in a lower level of care 4. Member is assessed to be at risk of requiring higher levels of care if not engaged in CPST treatment.	**All of the following criteria must be met:** 1. The member continues to meet admission criteria 2. One of the following is present: a. The member has an active goal and shows progress toward achieving it. b. The member has met and is sustaining a recovery goal, but would like to pursue a new goal related to a functional deficit in one of the above areas. c. The member requires a CPST level of care in order to maintain psychiatric stability; there is not a less restrictive level of care that is appropriate or without CPST services; and the individual would require a higher level of care.	**Any one of the following must be met:** 1. The member no longer meets PRS LOC criteria. 2. The member has sustained recovery goals for three to six months and a lower level of care is clinically indicated. 3. The member has achieved current recovery goals and can identify no other goals that would require additional CPST services in order to achieve those goals. 4. The member is not participating in a recovery plan and is not making progress toward any goals. 5. Extensive engagement efforts have been exhausted and there is insignificant expected benefit from continued participation. 6. The member can live, learn, work and socialize in the community with supports from natural and/or community resources.

J. Assertive Community Treatment (ACT)

The purpose of ACT is to deliver comprehensive and effective services to individuals who are diagnosed with severe mental illness and whose needs have not been well met by more traditional service delivery approaches. ACT provides an integrated set of other evidence- based treatment, rehabilitation, case management, and support services delivered by a mobile, multi-disciplinary mental health treatment team. ACT supports recipient recovery through a highly individualized approach that provides recipients with the tools to obtain and maintain housing, employment, relationships and relief from symptoms and medication side effects. The nature and intensity of ACT services are developed through the person-centered service planning process and adjusted through the process of team meetings.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
Criteria 1 - 5 must be met; Criteria 6 & 7 may also be met: 1. Severe and persistent mental illness (including, but, not limited to diagnoses of schizophrenia, schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), bipolar disorder and/or major or chronic depression), that seriously impairs their functioning in the community. 2. Recipients with serious functional impairments should demonstrate at least one of the following conditions: a. Inability to consistently perform practical daily living tasks required for basic adult functioning in the community without significant support or assistance from others such as friends, family or relatives. b. Inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role. c. Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing). 3. Recipients with continuous high service needs should demonstrate one or more of the following conditions: a. Inability to participate or succeed in traditional, office-based services or case management.	1. Initial authorization criteria continue to be met. 2. A comprehensive assessment is completed within 30 days of admission, with specific objectives and planned services to achieve recovery goals. Service plan is reviewed for progress and updated every six months as necessary 3. Continued coordination of care with other providers/stakeholders such as PCPs, specialty providers, inpatient treatment team, AOT, community supports, family, etc. 4. Active discharge planning is ongoing, with goal of transitioning the member to a less intensive LOC, when appropriate.	**Criteria 1, 2, 3, or 4 are suitable; Criteria 5 & 6 are recommended, but optional:** ACT recipients meeting any of the following criteria may be discharged: 1. Individuals who demonstrate, over a period of time, an ability to function in major life roles (i.e., work, social, self-care) and can continue to succeed with less intensive service. 2. Individuals who move outside the geographic area of the ACT team's responsibility, subsequent to the transfer of care to another ACT team or other appropriate provider and continued services until the member is engaged in care. 3. Individuals who need a medical nursing home placement, as determined by a physician. 4. Individuals who are hospitalized or locally incarcerated for three months or longer. However, an appropriate provision must be made for these individuals to return to the ACT program upon their release from the hospital or jail. 5. Individuals who request discharge, despite the team's best, repeated efforts to engage them in service planning. Special care must be taken in this situation to arrange alternative treatment when the recipient has a history of suicide, assault or forensic involvement.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
b. High use of acute psychiatric hospitals (two hospitalizations within one year, or one hospitalization of 60 days or more within one year). c. High use of psychiatric emergency or crisis services. d. Persistent severe major symptoms (e.g., affective, psychotic, suicidal or significant impulse control issues). e. Co-existing substance abuse disorder (duration greater than six months). f. Current high risk or recent history of criminal justice involvement. g. Court ordered pursuant to participate in AOT. h. Inability to meet basic survival needs or homeless or at imminent risk of becoming homeless. i. Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent setting if intensive community services are provided. j. Currently living independently but clinically assessed to be at immediate risk of requiring a more restrictive living situation (e.g., community residence or psychiatric hospital) without intensive community services.		6. Individuals who are lost to follow- up for a period of greater than three months after persistent efforts to locate them, including following all local policies and procedures related to reporting individuals as "missing persons", including, but, not limited to, conferring with Health Homes and MMCO/HARPs, to which member may be assigned.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
4. Member has been assessed and is not an immediate danger to self or others and does not require 24-hour medical supervision. 5. Member's condition is such that it can be expected to benefit and improve significantly through appropriate ACT interventions. 6. Member is stepping down from a higher LOC and requires more intensive services than routine outpatient behavioral health treatment or other community based supports; and/or has past history of a similar clinical presentation where less intensive treatment was not sufficient to prevent clinical deterioration and the need for a higher L O C . 7. For children or adolescents, the parent or guardian agrees to participate in the member's treatment plan, as appropriate. 8. Priority is given to individuals with SMI, individuals with continuous high service needs that are not being met in more traditional service settings, and individuals with ACT in their AOT order 9. Exclusion criteria: Individuals with a primary diagnosis of a substance abuse disorder or mental retardation and members with a sole diagnosis of a personality disorder are not appropriate for ACT 10. The member is not enrolled in HCBS services other than crisis residential services.		

SECTION III: DIVERSIONARY SERVICES

This section outlines services provided to members who are experiencing a behavioral health crisis and require an emergency evaluation.

A. Emergency Screening/Crisis Evaluations

Beacon promotes access to Emergency care without requiring prior authorization or notification from the member. Beacon, however, does require a face-to- face evaluation by a licensed clinician for all members requiring acute services. There is no level of care criteria for ESP services.

B. Comprehensive Psychiatric Emergency Program (CPEP)

Comprehensive Psychiatric Emergency Program (CPEP) is a licensed, hospital based psychiatric emergency program that establishes a primary entry point to the mental health system for individuals who may be mentally ill to receive emergency observation, evaluation, care and treatment in a safe and comfortable environment. Emergency visit services include provision of triage and screening, assessment, treatment, stabilization and referral or diversion to an appropriate program. Brief emergency visits require a psychiatric diagnostic examination and may result in further CPEP evaluation or treatment activities, or discharge from the CPEP program. Full emergency visits, which result in a CPEP admission and treatment plan, must include a psychiatric diagnostic examination, psychosocial assessment and medication examination. Extended Observation Beds operated by the CPEP Program are usually located in or adjacent to the CPEP emergency room, are available 24 hours per day, seven days per week to provide extended assessment and evaluation as well as a safe and comfortable environment for up to 72 hours for persons, who require extensive evaluation, assessment, or stabilization of their acute psychiatric symptoms. There is no level of care criteria for CPEP services.

C. Mobile Crisis Intervention

Mobile Crisis Intervention services are provided as part of a comprehensive specialized psychiatric services program available to all Medicaid eligible adults with significant functional impairments meeting the need levels in the 1915(i)-like authority resulting from an identified mental health or co-occurring diagnosis. Mobile Crisis Intervention services are provided to a person who is experiencing or is at imminent risk of having a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis including a preliminary assessment, immediate crisis resolution and de-escalation. Services will be geared towards preventing the occurrence of similar events in the future and keeping the person as connected as possible with environment/activities. The goals of Mobile Crisis Intervention services are engagement, symptom reduction, and stabilization. All activities must occur within the context of a potential or actual psychiatric crisis.

D. Short Term Crisis Respite

Short-term Crisis Respite is a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the person's home and community environment without onsite supports including:

- A mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others
- A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support
- When there is an indication that a person's symptoms are beginning to escalate

Referrals to Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an inpatient setting. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.

E. Intensive Crisis Respite

Intensive Crisis Respite (ICR) is a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms. In addition, the person must be able to contract for safety.

Individuals in need of ICR are at imminent risk for loss of functional abilities, and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization.

SECTION IV: OUTPATIENT BEHAVIORAL HEALTH SERVICES

This section contains service descriptions and LOC criteria for the following outpatient behavioral health services:

A. Outpatient Behavioral Health

B. Outpatient Psychiatric Home Based Therapy (HBT) and Home Based Therapy-Plus (HBTP)

C. Psychological & Neuropsychological Testing

D. Applied Behavioral Analysis (ABA)

E. Developmental Screening

F. Psychiatric Home Care

G. Opioid Replacement Therapy

H. Buprenorphine Maintenance Treatment (BMT)

Beacon's utilization management of outpatient behavioral health services is based on the following principles:

- Outpatient treatment should result in positive outcomes within a reasonable time frame for specific disorders, symptoms and/or problems. The evaluation of goals and treatment should be based on the member's diagnosis, symptoms, and level of functioning;
- Treatment should be targeted to specific goals that have been mutually negotiated between provider and the member. Goals of initial and extended outpatient therapy may include crisis resolution, symptom reduction, stabilization, improvement in adaptation, and/or recovery from addiction;
- Treatment modality, frequency and length of treatment should be individualized for each member. Most clinical situations can be effectively managed using a short-term and/or intermittent model of treatment with varying modalities and frequency of contact, as needed;
- Individuals with chronic or recurring behavioral health disorders may require a longer term approach with intermittent visits over extended periods, or sustained contacts with increased intensity of services around periods of relapse or decompensation; and
- Members must have flexibility in accessing outpatient treatment, including transferring.

Please note that visits for psychopharmacology evaluation and management (E/M) and group therapy visits are not subject to this preauthorization process. Outpatient psychotherapy, including initial evaluations, do not require an authorization prior to the start of treatment; however, each health plan will set threshold limits/initial encounters (IEs) for some psychotherapy services. Once the limit is reached, an authorization for additional sessions can be requested from beacon via eServices.

A. Outpatient Behavioral Health

Outpatient behavioral health treatment is an essential component of a comprehensive health care delivery system. Individuals with major mental illnesses, chronic and acute medical illnesses, substance use disorders, family problems, and a vast array of personal and interpersonal challenges can be assisted in coping with difficulties through comprehensive outpatient treatment. The goal of behavioral health treatment is to assist members in their achievement of a greater sense of well-being and return to their baseline, or higher level of functioning. Efficiently designed BH interventions help individuals and families effectively cope with stressful life situations and challenges. (See continuation of level of care, next page)

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
Criteria #1 or criteria # 2 – 5 must be met; for Telehealth # 6 and 7 must also be met; and none of #8 - 12 are met: 1. Member has a DSM or corresponding ICD psychiatric or substance use disorder.	**All of the following criteria must be met:** 1. Evidence suggests that the defined problems are likely to respond to current treatment plan. 2. Member progress is monitored regularly and the treatment plan modified if member is not	**Criteria #1 and any one of # 2 - 8 must be met:** 1. Member has demonstrated sufficient improvement and is able to function adequately without any evidence of risk to self or others. 2. The member is able to function adequately without significant impairment in psychosocial

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
2. Member has psychiatric symptoms, behavioral or cognitive impairment consistent with DSM or corresponding ICD diagnoses. 3. Member is experiencing at least moderate symptomatic distress or functional impairment due to psychiatric symptoms in at least one area of functioning (e.g. self-care, occupational, school, or social function) 4. Without treatment, member would be at risk to require a more intensive level of care (LOC). 5. Treatment expectations must include: a. Goal of therapy is to return member to an adequate level of functioning and to help member develop skills to deal effectively with the specific issues of concern. b. Psychopharmacology assessment should be considered on initial evaluation and throughout the treatment process if progress is minimal. c. Frequency of treatment contact matches the intensity/severity of the clinical situation. d. Treatment planning encourages member autonomy and independent functioning (seeing the member on an intermittent basis serves this function).	making substantial progress toward a set of clearly defined goals. 3. Goals for treatment are specific and targeted to member's clinical issues (A specific treatment plan is in place in the member's chart). 4. Treatment planning is individualized and appropriate to member's changing condition with realistic goals stated. 5. Frequency (intensity) of treatment contact matches the severity of current symptoms (intermittent treatment allowing the member to function with maximal independence is the goal). 6. Evidence exists that member is at current risk for higher levels of care if treatment is discontinued. 7. Treatment planning for children and adolescents or adults includes family or other support systems, as appropriate.	Functioning, indicating that continued outpatient therapy is not required. 3. Member has substantially met the specific goals outlined in treatment plan (there is resolution or acceptable reduction in target symptoms that necessitated treatment). 4. Member has attained a level of functioning that can be supported by self-help or other community supports. 5. Evidence does not suggest that the defined problems are likely to respond to continued outpatient treatment. 6. Member is not making progress toward the goals and there is no reasonable expectation of progress with the current treatment approach. 7. Current treatment plan is not sufficiently goal oriented and focused to meet behavioral objectives. 8. The member no longer meets admission or continued treatment criteria.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
e. From the outset of treatment, clear criteria or goals are developed (with the member) that define progress and indicate when the member will no longer require treatment. f. Treatment is goal-oriented and time-limited with specific focus on the behavioral health issues that require intervention (and that would pose a further risk of impairment if not addressed). g. Therapy with children/adolescents includes family involvement unless contraindicated and documented; individual visits with a child or young adolescent in a school, clinic or home context, where parent/guardian involvement is not indicated, does not meet LOC criteria for effective therapy. h. There is an expectation that member has the capacity to make significant progress toward treatment goals or that treatment will be effective in preventing the member's condition from worsening 6. Treatment is for psychopharmacological evaluation and management as well as psychotherapy.		

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
7. Geography, specialty or linguistic capacity dictates that in-office visits are not within a reasonable distance. **Any of the following criteria is sufficient for exclusion from this LOC:** 8. Treatment focus other than active symptoms of DSM or corresponding ICD diagnoses (e.g., marital communication.) 9. Therapy for personal growth or longer-term character change. 10. Economic or educational issues (e. g., need for housing or a special school program.) 11. Concerns related to physical health without a concomitant behavioral health diagnosis. 12. Treatment as an alternative to incarceration.		

B. Outpatient Psychiatric Home Based Therapy (HBT) and Home Based Therapy-Plus (HBTP)

Home-Based Therapy (HBT) is a short-term service for members who require additional support to:

- successfully transition from an acute hospital setting to their home and community, or
- Safely remain in their home or community when they experience a temporary worsening, or new behavioral health need, that may not be emergent, but without timely intervention could result in the need for a more intensive level of care than traditional outpatient treatment.

HBT brings the clinician to the member when there are delays or barriers to the member's timely access to a therapist. The HBT appointment is scheduled to occur within 48 hours of discharge from an acute mental health inpatient setting. The Beacon UR clinician may request that the HBT nurse/therapist visit the member in the hospital prior to discharge to explain HBT and ensure the member's willing participation in the service. This level of care (LOC) requires a safe home environment that poses no safety risk to the HBT clinician. The HBT clinician does not replace the outpatient therapist, but reinforces the aftercare plan, assists to overcome any potential or identified barriers to care, helps identify resources for necessary community-based services, and bridges any delays or gaps in service. The HBT clinician may also work with the member's family to increase understanding of the member's condition and the importance of adherence. HBT may also be deployed to help a member avert acute hospitalization during a brief period of destabilization.

Home-Based Therapy-Plus (HBTP)

HBTP is appropriate for members who meet the following criteria:

1. History of treatment non- which has resulted in poor functionality in the community
2. History of two or more admissions in less than 12 months
3. Presence of co-occurring medical and BH disorders
4. First inpatient admission for a major mental illness (e.g. bipolar disorder, schizophrenia, major depression

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
Criteria # 1 - 5 must ALL be met; and at least one of criteria # 6 – 7 must also be met: 1. Member must have a DSM or corresponding ICD diagnosis of a psychiatric disorder. 2. Member can be maintained adequately and safely in their home environment. 3. Member has the capacity to engage and benefit in treatment. 4. Member agrees to participate in psychiatric home based treatment. 5. Member's level of functioning in areas such as self- care, work, family living, and social relations is impaired.	**Criteria # 1 - 6 must ALL be met:** 1. Member continues to meet admission criteria and another less intensive LOC is not appropriate. 2. Member is experiencing symptoms of such intensity that if discharged, member would likely require a more intensive LOC. 3. Member progress is monitored regularly, and the treatment plan modified, if the member is not making substantial progress toward a set of clearly defined and measurable goals. 4. Member appears to be benefiting from the service. 5. Member is compliant with treatment plan and continues to be motivated for services.	**Criteria # 1, 2, 3 or 4 are suitable; Criteria # 5 and 6 are recommended, but optional:** 1. Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive. 2. Member or parent/guardian withdraws consent for treatment. 3. Member and/or parent/caregiver do not appear to be participating in the treatment plan. 4. Member is not making progress toward goals, nor is there expectation of any progress.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
6. Member has social/emotional barriers that cannot be adequately managed in an office based program setting. 7. Member has history of non-compliance in terms of routine office based services which has recently resulted in placement in a more intensive LOC. **For HBTP, at least one from Criteria 8 through 11 must also be met:** 8. History of 2 or more admissions in less than 12 months 9. Presence of co-occurring medical and BH disorders. 10. First inpatient admission for a major mental illness (e.g. bipolar disorder, schizophrenia, major depression 11. History of treatment which has resulted in poor functionality in the community	6. Coordination of care and active discharge planning is ongoing, with goal of transitioning the member to a less intensive LOC.	5. Member's individual treatment plan and goals have been met. 6. Member's support system is in agreement with the aftercare treatment plan

C. Psychological & Neuropsychological Testing

Psychological Testing uses standardized assessment tools to gather information relevant to a member's intellectual and psychological functioning. Psychological Testing can be used to determine differential diagnosis and assess overall cognitive functioning related to a member's mental health or substance abuse status. Test results may have important implications for treatment planning.

A licensed psychologist performs Psychological Testing, either in independent practice as a health services Provider or in a clinical setting.

Psychological Testing: Beacon reimburses for the following procedure codes for psychological testing:

- 96101, 96102, 96103 Psychological Testing:

- Includes psycho-diagnostic assessment of personality and intellectual abilities, (e.g., WAIS-R, Rorschach, TAT, MMPI) with interpretation and report, per hour

- 96118, 96119, 96120 Neuropsychological Testing:
  - Includes assessment of neuropsychological functioning that is tailored to the clinical needs of clients; utilizes a variety of assessment devices, which focus on cognitive ability, attention, concentration, language functions, visual perceptual and visual motor functions, executive functions, memory, and motor skills.
  - Requires specialized neuropsychological training collected and verified at point of contracting via credentialing

* Beacon Network Inpatient and Acute Residential Treatment Facilities have an all-inclusive per diem rate which covers any needed psychological testing. Beacon does not reimburse individual Providers for psychological testing when it is conducted during the course of an inpatient or an acute residential treatment program stay.

1. Services to be reviewed by Beacon:

a. Reasons for referral for psychological testing:

- Member currently in behavioral health treatment, who has had a complete psychosocial evaluation with a BH provider (including family involvement when the member is a minor) but may require psychological testing to further assess a member's psychological functioning (reality testing, suicidal ideation, anxiety, cognitive functioning) in order to modify or revise an ongoing treatment plan.
  - Testing is not authorized as part of an initial evaluation and a period of psychotherapy and/or a consultation with a psychiatrist is generally recommended prior to a psychological testing referral.
- Evaluations for Attention Deficit Hyperactivity Disorder (ADHD) do not fall in the realm of formal psychological testing. Evaluations for ADHD consist of the completion of rating scales that are reviewed with the member (and his/her family) and a consult with a psychiatrist.

b. Reasons for referral for neuropsychological testing:

- Member is experiencing cognitive impairments that impede his/her ability to function on a day-to-day basis. As examples:
  - A member experiencing hallucinations may need a neuropsychological evaluation to rule out organic causes.
  - A member with a depressive disorder who is experiencing memory problems, may benefit from an assessment to better understand the type and severity of the memory problems and to assist in treatment planning; or
- A child may benefit from neuropsychological testing to assess the presence of a pervasive developmental disorder or autism.

- Areas of impairment may include: memory, attention, concentration; executive functioning (planning and organization); judgment, receptive and expressive language.

2. Services to be reviewed by Medical side of the Health Plan:

a. Reasons for referral for neuropsychological evaluation:

- Member has suffered trauma to the head (e.g., in auto accident) or has suffered from a cerebral insult due to stroke, aneurysm, or other medical condition or biological insult (e.g., degenerative disease, lead poisoning, dementia), resulting in problems with thinking, memory, attention, and/or executive functioning.
- The goal of neuropsychological testing, in these situations, is to assess the member's impairment in functioning due to the medical condition or biological insult. This information can then be used to inform medical management.

  Note: The member is usually not receiving mental health services.

b. Reasons for referral for developmental evaluation:

Pediatrician requests developmental evaluation for young child under the age of four with no behavioral health history, diagnosis, or symptoms.

3. Services that are not covered [Exclusions]:

- Testing for academic, educational or learning problems including: Nonverbal learning disabilities, dyslexia, sensory integration, central auditory processing, speech/language problems and OT or PT issues;
- Psychological evaluations to determine parental competency;
- Testing when the member has used illicit substances in the past 60 days;
- Testing for vocational guidance;
- Testing for legal or administrative purposes;
- A request for re-testing when the member was tested in the past 12 months; and
- Testing at a provider site that is not in the Beacon network.

*Assessment of possible learning disabilities is provided by the school system in accordance with state and federal mandates.

Please Note: All requests should be in writing on the Beacon psychological testing form and must be performed on an outpatient basis by an in-network licensed psychologist.

ADMISSION CRITERIA	CRITERIA FOR TESTS	NON-REIMBURSABLE TESTS
The following criteria must apply: **A. Psychological testing: #1 - 3 must be met:** 1. The member has not been tested in the last 12 months or recently enough to make proposed tests duplicative or invalid. 2. The member is presently in active treatment, has had a comprehensive diagnostic evaluation, including an assessment of psychosocial functioning, and has been evaluated by a psychiatrist prior to testing. 3. The member has not been actively using illicit substances for a 2 month period prior to the initiation of testing. **B. Neuropsychological testing: #4 - 5 must be met:** 4. The member is experiencing cognitive impairments; 5. The member has had a comprehensive evaluation by a psychiatrist, psychologist, or developmental/ behavioral pediatrician; **C. In addition, any one of #6 - 10 must be met:** 6. The proposed test are empirically related to the specific question(s) to be answered by the evaluation and cannot be answered using other means of evaluation;	1. Tests must be published, valid, and in general use as evidenced by their presence in the current edition of the *Mental Measurement Yearbook*, or by their conformity to the *Standards for Educational and Psychological Tests* of the American Psychological Association. 2. Tests are administered individually and are tailored to the specific diagnostic questions of concern.	1. Self-rating forms and other paper and pencil instruments, unless administered as part of a comprehensive battery of tests, (e.g., *MMPI or PIC*) as a general rule. 2. Group forms of intelligence tests. 3. Short form, abbreviated, or “quick” intelligence tests administered at the same time as the *Wechsler or Stanford-Binet* tests. 4. A repetition of any psychological tests or tests provided to the same member within the preceding six months, unless documented that the purpose of the repeated testing is to ascertain changes: a. Following such special forms of treatment or intervention such as ECT; b. Relating to suicidal, homicidal, toxic, traumatic, or neurological conditions. 5. Tests for adults that fall in the educational arena or in the domain of learning disabilities. 6. Testing that is mandated by the courts, DCYF or other social/legal

ADMISSION CRITERIA	CRITERIA FOR TESTS	NON-REIMBURSABLE TESTS
7. Member's symptoms indicate a new or different diagnosis may be operative; 8. Member's functional status has markedly changed and testing is required to assist in establishing appropriate levels of care and treatment planning; 9. The focus or method of a prior evaluation is inappropriate for the member's current needs and the requested evaluation is necessary for appropriate assessment; OR 10. It is established that the evaluation is directly relevant to the member's mental health status and current treatment needs.		agency in the absence of a clear clinical rationale. **Please Note:** Beacon will not authorize periodic testing to measure the member's response to psychotherapy.

D. Intensive Behavioral Intervention (IBI) (or Applied Behavioral Analysis [ABA]) for individuals diagnosed with Pervasive Developmental Disorder, Not Otherwise Specified (PDD, NOS), Autistic Disorder, or Asperger's Disorder, delivered in the home, or community office setting.

ABA is defined as the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
All of the following criteria must be met: 1. Member has a DSM diagnosis of PDD, NOS, Autistic Disorder or Asperger's Disorder (collectively referred to as Autism Spectrum Disorder [ASD]) or corresponding ICD codes.	**All of the following criteria must be met:** 1. Member continues to meet admission criteria and does not meet criteria for another LOC, either more or less intensive.	**Criteria # 1, 2, 3, 4, 5, or 6 are suitable; Criterion # 7 is recommended, but optional:**

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
2. Member has been evaluated and diagnosed by a child psychiatrist, developmental pediatrician, pediatric neurologist or psychologist with developmental or child /adolescent expertise, and has a. received a comprehensive medical evaluation to exclude any underlying medical etiologies; b. received formal diagnostic and/or functional assessment (e.g. ABLLS-R, Vineland-II , M-CHAT-R, ADI-R, ADOS-G, CARS2, VB-MAPP or Autism Behavior Checklist) 3. Provider and/or supervisor of the IBI/ABA and treatment plan development is a certified behavioral analyst as evidenced by certification by the Behavior Analyst Certification Board (BCBA). 4. Member has specific, challenging behavior(s) attributable to the ASD (e.g. self-injurious, stereotypic/repetitive behaviors, aggression toward others, elopement, severely disruptive behaviors) which result(s) in significant impairment in one or more of the following: a. personal care b. psychological function c. adaptive function	2. Treatment is still necessary to reduce symptoms and improve function so the member may be treated at a less restrictive LOC. 3. Member's progress is monitored regularly evidenced by behavioral graphs, progress notes, and daily session notes. The treatment plan is to be modified, if there is no measurable progress toward decreasing the frequency, intensity and/or duration of the targeted behaviors and/or increase in skills for skill acquisition to achieve targeted goals and objectives. 4. Supervision of paraprofessionals working on member's case required by a BCBA overseeing treatment. 5. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out. 6. Parent / guardian / caregiver are involved in training in behavioral interventions and continue to participate in and be present for at least 50% of treatment sessions. Progress of parent skill development in behavior management interventions is being monitored. 7. As member makes progress evidenced by reduction in rates, intensity and duration of maladaptive behaviors and increase in skill acquisition, service authorization will reflect new presentation. 8. Coordination of care and discharge planning are ongoing with the goal of transitioning member to less intensive behavioral intervention and a less intensive LOC.	1. Member no longer meets admission criteria and/or meets criteria for another LOC. 2. Member's individual treatment plan and goals have been met. 3. Parent / guardian / caregiver is capable of continuing the behavioral interventions. 4. Parent / guardian withdraws consent for treatment. 5. Member or parent / guardian / caregiver does not appear to be participating in treatment plan and/or be involved in behavior management training. 6. Member is not making progress toward goals, nor is there any expectation of progress. 7. Member's support system is in agreement with the transition/discharge treatment plan.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
d. social function 5. Member can be maintained adequately and safely in their home environment. Member does not require a more intensive level of care due to imminent risk to harm self or others or based on severe maladaptive behaviors. 6. Member's treatment/intervention plan includes clearly defined behavioral interventions with measurable behavioral goals that address the identified challenging behavior(s). Intervention(s) are appropriate for member's age and impairments. 7. Member's challenging behavior(s) and/or level of function can be expected to improve with IBI/ABA. 8. Parent / guardian / caregiver agrees to participate in and be present during at least 50% of treatment sessions (including face to face parent training on behavior management interventions) unless clinically indicated otherwise. 9. Member currently receives no other in home or office based IBI/ABA services.		

E. Developmental Screening (article 28 and 31 clinics only)

Developmental screening provides parents and professionals with information on whether a child's development is similar to other children of the same age. Screening always involves the use of a standardized tool. Screening tool questions are based on developmental milestones and designed to answer the question, "Is this child's development like other children of the same age?" Ideally, screening is an ongoing process involving repeat administration of a tool, along with continuous, quality observations made by adults familiar with the child.

Screening does not give a diagnosis, but identifies areas in which a child's development differs from same-age norms. Concerning screening results indicate the need for further assessment to determine a child's strengths and needs.

To read The American Academy of Pediatrics definition of developmental screening, click here (http://www.aap.org/healthtopics/early.cfm). The AAP now recommends developmental screening of all children at ages 9-, 18-, and 30-months. Targeted screening happens when screening is conducted because of concerns about a child.

Article 28 and 31 clinics will be reimbursed for up to 4 units (hours) of developmental screening without prior authorization. For additional units, providers may request the Developmental Screening Supplemental Form.

F. Psychiatric Home Care

Psychiatric Home Care is treatment that is delivered in a member's home or in their living environment in order to treat a DSM or corresponding ICD diagnosis. This service must be provided by an accredited home care agency and the clinical service must be provided by a licensed mental health professional. Psychiatric Home Care may be authorized for a variety of circumstances (e. g., member is homebound or has difficulty ambulating or is unlikely to get to the community mental health provider). For all home care agencies, a written physician order for Psychiatric Home Care services must be in place at the time the service is requested and a physician must be available for consultation and is integrated into treatment plan. The frequency of visits varies depending on level of acuity.

- **Authorization Procedures** - Beacon requires a call from the provider to pre-certify a psychiatric home care evaluation. After the evaluation is completed, the provider will call with clinical information including the member's diagnosis, treatment plan and discharge plan.
- **Written Notification** - Beacon sends an authorization letter to the Provider, including the Prior Authorization Number within 1 business day after the review is completed.
- **Extension requests** - Prior to the end date of the existing authorization, the Provider may request an extension of services.

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
Criteria # 1 -6 must ALL be met: 1. Member must have a DSM or corresponding ICD diagnosis.	**Criteria # 1 - 7 must ALL be met and at least one from criteria # 8- 9 must be met:** 1. Member continues to meet admission criteria and another LOC is not appropriate.	**Criteria # 1, 2, or 3, are suitable; criteria # 4 and 5 are recommended, but optional:** 1. Member no longer meets admission criteria and/or meets criteria for

ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
2. Member can be adequately and safely maintained in the home environment. 3. Member is motivated to receive this service and is willing to participate and comply with the developed treatment plan. 4. Member requires coordination of services with other providers and other support services. 5. Member requires assistance to adhere to safe administration of medication regimen. 6. Psychiatric home care is believed to be necessary to prevent placement in a higher level of care.	2. Treatment is still necessary to reduce symptoms and improve functioning. 3. Member progress is monitored regularly, and the treatment plan modified, toward a set of clearly defined and measurable goals. 4. Member appears to be benefiting from the service. 5. Member is compliant with treatment plan and continues to be motivated for services. 6. Coordination of care and active discharge planning is ongoing, with goal of transitioning the member to a less intensive LOC. 7. Continuation of psychiatric home care is believed to be necessary in order to prevent placement in a higher LOC. 8. Member has complex co-morbid issues that require skilled nursing and behavioral health supervision. 9. Member is still not able to follow medication regimen without this level of support (and there is a lack of social support at home.)	another LOC, either more or less intensive. 2. Member or guardian withdraws consent for treatment. 3. Member does not appear to be participating in the treatment plan. 4. Member's individual treatment plan and goals have been met. 5. Member's support system is in agreement with the aftercare treatment plan.

G. Opioid Replacement Therapy

Opioid replacement therapy is the medically monitored administration of methadone, buprenorphine, or other U.S. Food and Drug Administration (FDA) approved medications to opiate-addicted individuals, in conformance with FDA and Drug Enforcement Administration (DEA) regulations. This service combines medical and pharmacological interventions with counseling, educational and vocational services and is offered on a short-term (detoxification) and long-term (maintenance) basis.

H. Buprenorphine Maintenance Treatment (BMT)

See ASAM Level 1 Criteria. For Medicaid, FIDA and Dually Eligible members, please refer to the LOCATDR Criteria.

SECTION V: OTHER SPECIAL BEHAVIORAL HEALTH SERVICES

This section contains other special Behavioral Health service descriptions and level of care criteria for the following:

A. Electro-Convulsive Therapy (ECT)

B. Pre-vocational Services

C. Transitional Employment

D. Intensive Supported Employment (ISE)

E. Ongoing Supported Employment

F. Education Support Services

G. Empowerment Services - Peer Supports

H. Habilitation/Residential Support Services

I. Family Support and Training

Please note: Use of this level of care is specific to a Health Plans authorization requirements.

J. Transcranial Magnetic Stimulation

A. Electro-Convulsive Therapy (ECT)

Electro-Convulsive (ECT) Therapy is the initiation of seizure activity with an electric impulse while the member is under anesthesia. This procedure is administered in a hospital facility licensed to do so by the Department of Health and Mental Hygiene (DHMH). ECT may be administered on either an inpatient or outpatient basis, depending on the member's mental and medical status. Regulations governing administration of this procedure are contained in DHMH regulations.

The principal indication for ECT is major depression with melancholia. The symptoms that predict a good response to ECT are early morning awakening, impaired concentration, pessimistic mood, motor restlessness, speech latency, constipation, anorexia, weight loss, and somatic or self- deprecatory delusions, all occurring as part of an acute illness.

Providers must complete a work-up including medical history, physical examination, and any indicated pre-anesthetic lab work to determine that there are not contra-indications to ECT and that there are no less intrusive alternatives to ECT before scheduling administration of ECT. The member must provide separate written informed consent to ECT on forms provided by the DHMD C o n s e n t to other forms of psychiatric treatment is not considered to include consent to ECT. The member should be fully informed of the risks and benefits of this procedure and of any alternative somatic or non-somatic treatments.

INITIAL AUTHORIZATION CRITERIA	CONTINUED AUTHORIZATION CRITERIA	DISCONTINUATION CRITERIA
All criteria must be met: 1. Member must have DSM or corresponding ICD diagnosis of major depression, schizophrenia, or mood disorder with features that include mania and/or psychosis and/or catatonia. 2. ECT is utilized when: a. Member has been medically cleared and there are no intracranial or cardiovascular contraindications; b. There is a need for a rapid definitive response on a psychiatric basis; c. The benefits of ECT outweigh the risks of other treatments. 3. Must meet all of the above and either one below: a. Member has not responded to medication trials b. Member has a history of positive response to ECT	**All of the following criteria must be met:** 1. Member continues to meet admission criteria and another level of care (LOC) is not appropriate. 2. Member has responded to treatment or there is an expectation that member will respond with further treatment. 3. Member agrees to continue with treatment. 4. Treatment is still necessary to reduce symptoms and improve functioning.	**Any one or more of the following are suitable:** 1. Member no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive. 2. Member withdraws consent for treatment and does not meet criteria for involuntary mandated treatment. 3. Member does not appear to be participating in the treatment plan. 4. Member is not making progress toward goals, nor is there expectation of any progress. 5. Member's individual treatment plan and goals have been met. 6. Member's natural support (or other support) systems are in agreement with following through with patient care, and the member is able to be in a less restrictive environment.

INITIAL AUTHORIZATION CRITERIA	CONTINUED AUTHORIZATION CRITERIA	DISCONTINUATION CRITERIA
c. Member requests ECT as a treatment option accompanied by criteria # 2 (a) and (c) above.		

B. Pre-vocational Services

Pre-vocational services are time-limited services that prepare a participant for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that that contribute to employability in competitive work environment as well as in the integrated community settings. Pre- vocational services occur over a defined period of time and with specific person centered goals to be developed and achieved, as determined by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual's person- centered plan of care, Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

C. Transitional Employment

Transitional Employment services are designed to strengthen the participant's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, psychosocial club program certified provider or recovery center. This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage.

D. Intensive Supported Employment (ISE)

ISE services that assist individuals with MH/SUD to obtain and keep competitive employment. These services consist of intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service will follow the evidence based principles of the Individual Placement and Support (IPS) model.

This service is based on Individual Placement Support (IPS) model which is an evidence based practice of supported employment. It consists of intensive supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting. Individual

employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support. Services that consist of intensive supports that enable participants for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting.

E. Ongoing Supported Employment

Ongoing supported Employment is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position. Individual employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

F. Education Support Services

Education Support Services are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education Support Services may consist of general adult educational services such as applying for and attending community college, university or other college-level courses. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the participant to participate in an apprenticeship program.

G. Empowerment Services - Peer Supports

Peer Support services are peer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (e.g. hope and self- efficacy, and community living skills). Peer support uses trauma-informed, non-clinical assistance to achieve long-term recovery from SUD and Mental health issues. Activities included must be intended to achieve the identified goals or objectives as set forth in the participants individualized recovery plan, which delineates specific goals that are flexibly tailored to the participant and attempt to utilize community and natural supports. The intent of these activities is to assist recipients in initiating recovery, maintaining recovery, sustaining recovery and enhancing the quality of personal and family life in long-term recovery. The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Persons providing these services will do so through the paradigm of the shared personal experience of recovery.

H. Habilitation/Residential Support Services

Habilitation services are typically provided on a 1:1 basis and are designed to assist participants with a behavioral health diagnosis (i.e. SUD or mental health) in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community based settings.

These services assist participants with developing skills necessary for community living and, if applicable, to continue the process of recovery from an SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable the participant to integrate full into the community and endure recovery, health, welfare, safety and maximum independence of the participant.

I. Family Support and Training

Training and support necessary to facilitate engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. This service is provided only at the request of the individual. A person- centered or person-directed, recovery oriented, trauma-informed approach to partnering with families and other supporters to provide emotional and information support, and to enhance their skills so that they can support the recovery of a family member with a substance use disorder/mental illness. The individual, his or her treatment team and family are all primary members of the recovery team.

Please note: Use of this level of care is specific to a Health Plans authorization requirements.

J. Transcranial Magnetic Stimulation

Repetitive transcranial magnetic stimulation (rTMS) is an office-based, noninvasive, non-convulsive therapy, FDA-approved for patients with unipolar major depression nonresponsive to at least one adequate antidepressant medication trial in the current episode, and not currently on any antidepressant therapy.[1] An electronic coil emits short pulses of magnetic energy over the scalp, which in turn generates a mild electrical current in the superficial, underlying brain tissue. Targeting mood regulating areas of the brain (generally the left prefrontal cortex), the purpose of rTMS is to decrease severity and duration of depressive symptoms. An extremely intensive treatment, rTMS is generally applied five days/week for six weeks, followed by a taper of six treatments over three weeks.[2, 3] Response rates (response defined as 50% improvement in objectively measured depressive severity) to this intensity are modest, at 24%, and remission rates even less at 18%.[2] Age over 654 and treatment resistance[2,4, 5] (defined as nonresponse to at least two full antidepressant medication trials[6]) are each predictive of even less robust response and remission rates with rTMS. Relatively safe, it does have occasional side effects of pain/headache, and there are rare case reports of seizure induction.[7, 8] There is no current information on the sustained effect of rTMS and no evidence to support maintenance rTMS. There are no studies, and few case reports on the use of rTMS in pregnancy. (There is evidence to support the relative safety of certain antidepressants and the use of ECT in pregnancy.) There are some contraindications to rTMS, primarily related to possible adverse effects of the electromagnetic fields on devices, implants or magnetic substances.
There are also relative diagnostic or medical contraindications, such as dementia, degenerative neurologic conditions, medically unstable conditions, history of stroke or severe head injury.[7,8] The limited potential benefit of rTMS must be weighed against these risks. When the following criteria are met, prior authorization is granted for a six (6) week course of rTMS, up to 30 visits, and six (6) taper treatments over three (3) weeks.

Depression nonresponsive to one antidepressant trial has a better remission rate from a second antidepressant trial (30.6%)[9] than from rTMS (18%),[2] making a second medication trial more efficacious and cost-effective in this group. The remission rates for medication trials after nonresponse to at least two antidepressant trials are significantly less (~13%),[6,9] and even lower for rTMS, making failure of two antidepressant trials the generally accepted definition of treatment resistant depression (TRD). In this difficult to treat population, the relative risks, benefits, time course, treatment history, efficacy, intensity, cost and response maintenance all need to be considered. Depressed elderly, medically complicated individuals with TRD (i.e. those for whom rTMS is a slow, high intensity, low benefit, low efficacy, low risk, high cost treatment) have a better remission rate with ECT (electroconvulsive therapy) (50-60%)[10, 11, 12] in a shorter period of time (2-4 weeks). ECT, generally provided in a medically monitored setting (e.g., a surgical recovery room) is associated with memory deficits (less and often transient with unipolar treatment[12]), and the risks associated with anesthesia. Thus, ECT is a relatively quick, high intensity, high benefit, high efficacy, moderate risk, and less costly treatment for this population. Successful ECT has a fairly high relapse rate,[11, 13] but there is evidence to support the use of medication13 and/or maintenance ECT to maintain response.[14]

While there is no evidence base to support the use of rTMS as a first-line, cost-efficient treatment for depression or TRD, on a case-by-case basis there may be compelling individual factors that support a trial of this high intensity, low efficacy somatic therapy. The following criteria serve as a guide to ensure appropriate member selection, risk and safety standards, provider qualifications, acute treatment (i.e. not maintenance), and standardized monitoring and documentation of response. The criteria weigh the relative risks and benefits and err on the side of safety, because of the limited potential benefit.

Provider Qualifications and Requirements:

The provider of rTMS must be a board certified, appropriately licensed psychiatrist, also certified by the rTMS device manufacturer to provide rTMS. The provider must use an evidence-based, validated depression monitoring tool (e.g. BDI,[15] PHQ-9,[16] or QIDS-SR 16[17]) to identify and document depression severity, response to treatment, and maintenance of response. The provider must submit a current, up dated copy of the self- administered monitoring tool with the initial request for rTMS prior authorization, and after 4 and 6 weeks of rTMS treatment, and when possible, at 6 months after the completion of the course of treatment (i.e. if the member is still in treatment with the psychiatrist). (See continuation of review criteria, next two pages.)

INITIAL AUTHORIZATION CRITERIA	CONTINUED AUTHORIZATION CRITERIA	DISCONTINUATION CRITERIA
Criteria # 1 –6 and # 11 and at least one of # 7 – 10 must be met: 1. Confirmed DSM or corresponding ICD diagnosis of Major Depressive Affective Disorder (MDD), severe degree without psychotic features, either single episode or recurrent a. Depression is severe as defined and documented by a validated, self- administered, evidence-based monitoring tool (e.g. QIDS-SR 16, PHQ-9, HAM-D or BDI, etc.). b. Note that active or recent substance misuse must be considered carefully in the differential diagnosis of major depressive disorder. c. Note that diagnosis of MDD cannot be made in context of current or past history of manic, mixed, or hypomanic episode. AND 2. Member does not have a DSM or corresponding ICD diagnosis of an acute or chronic psychotic disorder (e.g. schizophrenia or schizoaffective disorder) or current psychotic symptoms. AND 3. Member is at least 18 years of age. AND 4. The rTMS treatment is delivered by an FDA-approved device in a safe and effective manner following the manufacturer's protocol and parameters with no modifications unless supported by published scientific evidence. 5. The order for treatment is written by a physician who has examined the Member and reviewed the record, has experience in administering rTMS therapy, and directly	**All of the following criteria must be met:** 1. Member continues to meet initial authorization criteria and does not require a higher LOC. 2. Member has been adherent and agrees to continue with the treatment plan. 3. Member has not yet completed the full course of treatment (i.e. five treatments per week for six weeks, followed by six taper treatments over three weeks) 4. Provider has administered and submitted the required timely updated standardized depression severity tool (as in Prior Authorization Criteria #9)	**Any one or more of the following criteria are suitable:** 1. Member has completed the acute course of five treatments per week for six weeks, and up to six taper treatments over three weeks (further treatment is considered to be maintenance, for which there is no evidence) 2. Member withdraws consent for treatment 3. Member no longer meets authorization criteria and/or meets criteria for another LOC, either more or less intensive. 4. Provider has failed to monitor, document and/or report member response to treatment (as in Prior Authorization Criteria #9)

INITIAL AUTHORIZATION CRITERIA	CONTINUED AUTHORIZATION CRITERIA	DISCONTINUATION CRITERIA
supervises the procedure (on site and immediately available). AND 6. During the current episode the Member has had a trial of evidence-based psychotherapy known to be effective in the treatment of MDD of an adequate frequency and duration without significant improvement in depressive symptoms as documented by a validated, self-administered, evidence-based monitoring tool AND 7. Member has treatment resistant depression (TRD) as evidenced by lack of clinically significant response (less than 50% improvement in depressive symptoms documented on a validated, evidence-based monitoring tool), with good adherence, to at least four psychopharmacologic trials, in the current episode. a. Trials must be at or above the minimum effective dose and duration b. Trials must be from at least two different medication classes c. Trials must include at least two evidence-based augmentation therapies OR 8. Inability to tolerate psychopharmacologic agents as evidence by four trials of psychopharmacologic agents with intolerable side effects OR 9. Member has a documented history of response (at least 50% improvement in depressive symptoms documented on a validated, evidence-based monitoring tool) to a previous		

INITIAL AUTHORIZATION CRITERIA	CONTINUED AUTHORIZATION CRITERIA	DISCONTINUATION CRITERIA
course of rTMS, now has a relapse after remission and meets all other Admission Criteria OR 10. History of previous response to electroconvulsive therapy (ECT), or inability to tolerate ECT, and rTMS is considered a less invasive treatment option. 11. Member does not have any of the following:[7] a. History of seizures or seizure disorder (excluding ECT-induced seizures or febrile seizures in infancy requiring no further treatment) b. Neurologic conditions that include epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the central nervous system. c. Implanted medical device located <30 cm from the rTMS magnetic coil, including but not limited to implanted automatic defibrillators, pacemakers, or vagus nerve stimulators. d. Conductive, ferromagnetic or other magnetic-sensitive metals implanted in the head which are non-removable and within 30 cm of the TMS magnetic coil. Examples include shunts, clips, stents, cochlear/otologic implants, implanted electrodes/stimulators, bullets, pellets, metallic fragments and metallic tattoos. e. Vagus nerve stimulation (VNS) leads in the carotid f. Magnetically activated (not amalgam) dental implants		

[1] FDA definition in letter to Neuronetics, Inc. Re: K061053; NeuroStar® TMS System, Evaluation of Automatic Class III Designation, Regulation Number: www.accessdata.fda.gov/cdrh_docs/pdf6/K061053.pdf, accessed on 4/25/2011.

[2] O'Reardon JP, Solvason HB, Janicak PG, et al. Efficacy and safety of transcranial magnetic stimulation in the acute treatment of major depression: a multisite randomized controlled trial. Biol Psychiatry 2007;62:1208-16.

[3] Kennedy SH, Milev R Giacobbe P, et al. Cnadian network for mood and anxiety treatments (CANMAT) clinical guidelines for the management of major depressive disorder in adults. IV. Neurostimulation therapies. J Affect Disord 2009;117(Suppl 1):S44-53.

[4] George MS, Lisanby SH, Avery D, et al. Daily left prefrontal transcranial magnetic stimulation therapy for major depressive disorder: a sham-controlled randomized trial. Arch Gen Psychiatry 2010;67(5):507-16.

[5] Fregni F, Marcolin MA, Myczkowski M, et al. Predictors of antidepressant response in clinical trials of transcranial magnetic stimulation. Int J Neuropsychopharmacol
2006;9:641-54.

[6] Fava M. Diagnosis and definition of treatment-resistant depression. Biol Psychiatry 2003;53:649-59.

[7] Rossi S, Hallett M, Rossini PM, et al. Safety, ethical considerations and application guidelines for the use of transcranial magnetic stimulation in clinical practice and research. Clin Neurophysiol 2009;120(12):2008-39.

[8] Wassermann EM. Risk and safety of repetitive transcranial magnetic stimulation: report and suggested guidelines from the International Workshop on the Safety of Repetitive Transcranial Magnetic Stimulation, June 5-7, 1996. EEG Clin Neurophysiol 1998;108:1-16.

[9] Rush AJ, Trivedi MH, Wisniewski SR, et al. Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: a STAR*D report. Am J Psychiatry 2006;163:1905-17.

[10] Prudic J, Haskett RF, Mulsant B, et al. Resistance to antidepressant medications and short-term clinical response to ECT. Am J Psychiatry 1996;153:985-92.

[11] Kellner CH, Knapp RG, Petrides G, et al. Continuation electroconvulsive therapy vs pharmacotherapy for relapse prevention in major depression: a multisite study from the
Consortium for Research in Electroconvulsive Therapy (CORE). Arch Gen Psychiatry 2006;63:1337-44.

[12] Sackeim HA, Dillingham EM, Prudic J, et al. Effect of concomitant pharmacotherapy on electroconvulsive therapy outcomes: short-term efficacy and adverse effects. Arch
Gen Psychiatry 2009;66:729-37.

[13] Sackeim HA, Haskett RF, Mulsant BH, et al. Continuation pharmacotherapy in the prevention of relapse following electroconvulsive therapy: a randomized controlled trial. JAMA 2001;285:1299-1307.

[14] Andrade C, Kurinji S. Continuation and maintenance ECT: a review of recent research. J ECT 2002;18:149-58.

[15] Richter P, Werner J, Heerlien A, et al. On the validity of the Beck Depression Inventory, a review. Psychopathol 1998;31:160-8.

[16] Kroenke K, Spitzer RL. The PHQ-9: a new depression diagnostic and severity measure. Psychiatric Ann 2002;32:1-7.

[17] Rush AJ, Trivedi MH, Ibrahim HM, et al. The 16-item Quick Inventory of Depressive Symptomatology (QIDS), Clinician Rating (QIDS-C), and Self-Report (QIDS-SR): a psychometric evaluation in patients with chronic major depression. Biol Psychiatry 2003;54:573-83.

1.1. Health Plan-Specific Contact Addendum

HEALTH PLAN INFORMATION

Health plan name: Affinity Health Plan

Health plan EDI code: Payor ID: 43324 Plan ID: 009 & 164 (Enriched Health)

BEACON CONTACT INFORMATION

Beacon Hours of Operation: 24 hours/day

Beacon Ombudsperson: 1-800-974-6831

Beacon TTY: 1-866-727-9441

Beacon's Member Services: 1-800-974-6831

Beacon Clinical Appeals Coordinator Phone Number: 1-800-974-6831

Beacon Provider Relations: 1-800-974-6831

Interactive Voice Recognition (IVR): 1-888-210-2018

Beacon Claims Department:

Beacon Health Options
Claims Department
500 Unicorn Park Drive, Suite 103
Woburn, MA 01801-3393

CLAIMS TIMING INFORMATION

Plan/State Required Filing Notice Filing Limit:	Within 90 days of the dates of service
Time Limits for Filing Inpatient Claims:	Within 90 days of the date of discharge on inpatient claims
Time Limits for Filing Outpatient Claims:	Within 90 days of the dates of service on outpatient claims
Number of Days for Fair Hearing Decisions:	Expedited request 3 days. Standard request 30 days.

GOVERNMENT CONTACT INFORMATION

State Fair Hearing Office

NYS Office of Temporary and Disability Assistance

State Independent Review Organization

Office of Administrative Hearings

Managed Care Hearing Unit
P.O. Box 22023 Albany, NY 12201-2023

New York State Department of Financial Services
P.O. Box 7209
Albany, NY 12224-0209
Phone number: 1-800-400-8882
externalappealquestions@dfs.ny.gov

By Fax: 1-518-473-6735
To request in person:
40 North Pearl Street, 15th Floor
Albany, NY 12243
For additional information, visit:
www.otda.state.ny.us/oah

State Medicaid Office
New York State Department of Health Corning Tower,
Empire State Plaza Albany, NY 12237
Phone number: 1-800-541-2831 www.health.ny.gov