



Behavioral Health Policy and Procedure Manual for Providers / MVP Health Care



This document contains chapters 1-8 of Beacon's Behavioral Health Policy and Procedure Manual for providers. Please see the appendices for details regarding the Beacon services associated with your contracted plan. Additionally, all referenced materials are available on our website. Chapters that contain all level-of-care service descriptions and criteria will be posted on eServices; to obtain a copy, please email provider.relations@beaconhs.com or call provider relations at 1-844-265-7592.

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

CONTENTS

- Chapter 1: Introduction 1**
 - 1.1. Introduction to Beacon Health Strategies LLC2
 - 1.2. About this Provider Manual2
 - 1.3. Quality Improvement Efforts Focus on Integrated Care.....2
 - 1.4. Behavioral Health Services3
 - 1.5. Primary Care Provider Requirements for Behavioral Health.....3
- Medicare and Medicaid Requirements 4**
 - 2.1. About this Chapter5
 - 2.2. Provider Requirements5
- Network Operations 8**
 - 3.1. Network Operations9
 - 3.2. Contracting and Maintaining Network Participation9
 - 3.3. Provider Credentialing and Recredentialing9
 - 3.4. Organizational Credentialing..... 11
 - 3.5. Credentialing Process Overview 12
 - 3.6. Waiver Request Process 12
- Encounter Data, Billing, and Claims 13**
 - 4.1. General Claims Policies 14
 - 4.2. Electronic Billing 14
- Provider and Member Complaint and Appeals Process 32**
 - 5.1. Complaints and Grievances33
 - 5.2. Clinical Appeals Process 34
- Communicating with Beacon..... 41**
 - 6.1. Transactions and Communications with Beacon42
 - 6.2. Electronic Media 42
 - 6.3. Communication of Member and Provider Information.....44
 - 6.4. Beacon Provider Database45
 - 6.5. Other Benefits Information46
 - 6.6. Member Eligibility Verification Tools46
- Utilization and Care Management 48**
 - 7.1. Utilization Management 49
 - 7.2. Medical Necessity and Level of Care Criteria49
 - 7.3. Terms and Definitions52
 - 7.4. Accessibility Standards54
 - 7.5. Utilization Management Review Requirements55
 - 7.6. Care Management57

Quality Management and Improvement Program	59
8.1. Quality Management/Improvement Program Overview	60
8.2. Provider Role	60
8.3. Quality Monitoring	60
8.4. Treatment Records	61
8.5. Performance Standards and Measures	65
8.6. Practice Guidelines and Evidence-Based Practices	66
8.7. Outcomes Measurement.....	67
8.8. Communication between Outpatient Behavioral Health Providers and PCPs, Other Treaters.....	67
8.9. Communication between Inpatient/Diversionary Providers and PCPs, Other Outpatient Treaters.....	68
8.10. Reportable Incidents and Events	69
8.11. Provider Responsibilities.....	71

Chapter 1

Introduction

- 1.1. Introduction to Beacon Health Strategies LLC
- 1.2. About this Provider Manual
- 1.3. Quality Improvement Efforts Focus on Integrated Care
- 1.4. Behavioral Health Services
- 1.5. Primary Care Provider Requirements for Behavioral Health

1.1. Introduction to Beacon Health Strategies LLC

Beacon Health Strategies LLC and ValueOptions, Inc. merged in December 2014 and are now known as Beacon Health Options. Combined, we serve 45 million people across all 50 states and the United Kingdom, making us the premier managed behavioral health care company. BHS IPA is a subsidiary of Beacon Health Strategies and CHCS IPA is a subsidiary of ValueOptions.

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

1.2. About this Provider Manual

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

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

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

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

Additionally, this provider manual includes information regarding MVP Medicaid and Child Health Plus (CHP) plan requirements.

1.3. 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.

1.4. Behavioral Health Services

DEFINITION OF BEHAVIORAL HEALTH

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

ACCESSIBLE INTERVENTION AND TREATMENT

Beacon promotes 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

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

OUTPATIENT BENEFITS

Outpatient behavioral health treatment is an essential component of a comprehensive health care delivery system. Plan members may access outpatient mental health and substance use services by self-referring to a network provider, by calling Beacon, or by referral through acute or emergency room encounters. Members may also access outpatient care by referral from their primary care practitioners (PCP); however, a PCP referral is not required for behavioral health services

INPATIENT BENEFITS

The partner health plan/Beacon is responsible for authorizing inpatient hospital services, which includes services provided in free-standing psychiatric facilities.

1.5. 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.

Chapter 2

Medicare and Medicaid Requirements

- 2.1. About this Chapter
- 2.2. Provider Requirements

2.1. About this Chapter

This chapter sets forth provisions applicable to all services provided to all Medicare Advantage members, members covered by both Medicare and Medicaid (Duals), and to Medicaid members to the extent that a state has adopted the federal requirements referenced in this chapter as part of its Medicaid program. These terms are intended to supplement the Medicare Advantage and Medicaid requirements found in the Provider Services Agreements (PSAs) of providers participating in the Medicare Advantage and Medicaid products. In the event of a conflict between the provisions in this chapter and provisions found elsewhere in the Manual, the provisions of this chapter shall govern with respect to Medicare Advantage members, Medicaid members, and Duals.

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

2.2. Provider Requirements

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

- Not distribute any marketing materials, as such term is defined in 42 CFR Section 422.2260, to Medicare Advantage members or prospective Medicare Advantage members unless such materials have received the prior written approval of: (a) Beacon and, if required, (b) CMS and/or the applicable Plan. The provider shall further not undertake any activity inconsistent with CMS marketing guidelines as in effect from time to time. [42 CFR 422.2260, et seq.]
- Ensure that covered services are provided in a culturally competent manner. [42 CFR 422.112(a)(8)]
- Maintain procedures to inform Medicare Advantage members of follow-up care and, if applicable, provide training in self-care as necessary. [42 CFR 422.112(b)(5)]
- Document in a prominent place in the medical record of Medicare Advantage members if the member has executed an advance directive. [42 CFR 422.128 (b)(1)(ii)(e)]
- Provide continuation of care to Medicare Advantage members in a manner and according to time frames set forth in the PSA. If CMS imposes additional continuation of care criteria or time frames applicable to Medicare Advantage members, the provider shall comply with such additional CMS requirements as well as any requirements set forth in the PSA. [42 CFR 422.504(g)(2)(i) and (ii) and 42 CFR 422.504(g)(3)]
- In the event that the provider provides influenza and/or pneumococcal vaccines to patients, for any Medicare Advantage member, the provider shall provide such vaccines to Medicare Advantage members with no cost sharing. [42 CFR 422.100(g)(1) and (2)]
- Not discriminate against any Medicare Advantage member based upon the member's health status. [42 CFR 422.110(a)]

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

- Be accessible to Medicare Advantage members 24 hours per day, seven days per week when medically necessary. [42 CFR 422.112(a)(7)]
- Comply, as set forth in the PSA, with all applicable federal laws, including but not limited to, those federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse such as the False Claims Act and the federal anti-kickback statute. [42 CFR 422.504(h)(1)]
- Agree that Beacon and/or the applicable plan may notify all impacted Medicare Advantage members of the termination of the provider's participation in Beacon or the plan's provider network, as applicable. [42 CFR 422.111(e)]
- Disclose to CMS and to Beacon or the plan, quality and performance indicators, including disenrollment rates, member satisfaction rates and health outcomes to enable the plan to satisfy applicable CMS reporting requirements. [42 CFR 422.504 (f)(2)(iv)(A), (B), and (C)]
- Safeguard the privacy of any information that identifies a particular Member and maintain records in an accurate and timely manner. [42 CFR 422.118]
- Maintain and distribute to all employees and staff written standards of conduct that clearly state the provider's commitment to comply with all applicable statutory, regulatory, and Medicare program requirements (Code of Conduct) and require all employees and staff to certify that they have read, understand, and agree to comply with the standards. Require employees and staff to certify that in administering or delivering Medicare benefits, they are free of any conflict of interest as set forth in the provider's conflict of interest policy. [42 CFR 422.503(b)(4)(vi)(A), (E), and (F)] (Beacon may request annual certifications and documentation necessary to satisfy a regulatory audit of Beacon or the plan.)
- Comply with the requirements of the compliance programs (which include measures to prevent, detect, and correct Medicare non-compliance as well as measures to prevent, detect, and correct fraud, waste, and abuse) of plans that are Part C and Part D sponsors. Comply with and participate in, and require employees and staff to comply with and participate in, training and education given as part of the plan's compliance plan to detect, correct, and prevent fraud, waste, and abuse. [42 C.F.R. §422.503 and 42 C.F.R. §423.504]
- Monitor employees and staff on a monthly basis against the List of Excluded Individuals and Entities posted by the Office of the Inspector General of the Department of Health and Human Services and any applicable State Office of the Inspector General on their respective websites, the Excluded Parties List System, and the System for Award Management. [42 CFR 422.503(b)(4)(vi)(F)]
- Provide Beacon with written attestations documenting satisfaction of the requirements set forth above specific to the provider's Code of Conduct, compliance with the plan's fraud, waste, and abuse training, and the performance of monthly monitoring of employees and staff. [42 CFR 422.503(b)(4)(vi)(A), (C), and (D)]

The provider further acknowledges that:

- Beacon and/or plans may offer benefits in a continuation area for the members who move permanently out of the plan's service area. [42 CFR 422.54(b)]
- Beacon and/or plans will make timely and reasonable payment to, or on behalf of, a Medicare Advantage member for emergency or urgently needed services obtained by a member from a non-contracted provider or supplier to the extent provided by 42 CFR 422.100(b)(1)(ii).

Though it may not be applicable to the services provided by the provider, the plan will make available, through direct access and/or without member cost share as, and to the extent required by CMS, out-of-area renal dialysis services and certain other services, such as mammography, women's preventive services, and certain vaccines. [42 CFR 422.100(b)(1)(iv), 42 CFR 422.100(g)(1) and (2)]

Network Operations

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- 3.1. Network Operations
 - 3.2. Contracting and Maintaining Network Participation
 - 3.3. Provider Credentialing and Recredentialing
 - 3.4. Organizational Credentialing
 - 3.5. Credentialing Process Overview
 - 3.6. Waiver Request Process

3.1. Network Operations

Beacon's 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 8:00 a.m. and 8:00 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, 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 to members, 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.

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 mailing address provided in the Health Plan-Specific Contact Addendum. 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

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.

RECREREDENTIALING

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 (JCAHO), Council on Accreditation of Services for Family and Children (COA), or Council on Accreditation of Rehabilitation Facilities CARF), such accreditation must be in force and in good standing at the time of credentialing or recredentialing of the facility. If the facility is not accredited by one of these accreditation organizations, Beacon conducts a site visit prior to rendering a credentialing decision.

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

- Master's degree or above in a mental health field (including, but not restricted to, counseling, family therapy, psychology, etc.) from an accredited college or university 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

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@beaconhs.com.

3.5. Credentialing Process Overview

INDIVIDUAL PRACTITIONER CREDENTIALING	ORGANIZATIONAL CREDENTIALING
<p>Beacon individually credentials the following categories of clinicians in private or solo or practice settings:</p> <ul style="list-style-type: none"> ▪ 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 	<p>Beacon credentials and recredentials facilities and licensed outpatient agencies as organizations. Facilities that must be credentialed by Beacon as organizations include:</p> <ul style="list-style-type: none"> ▪ 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: <ol style="list-style-type: none"> 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.

Encounter Data, Billing, and Claims

- 4.1. General Claims Policies
- 4.2. Electronic Billing Requirements
- 4.3. Paper Claims Transactions
- 4.4. Additional Claims Information/Requirements
- 4.5. Provider education and Outreach
- 4.6. Coding

4.1. General Claims Policies

This chapter presents all information needed to submit claims to Beacon Health Options. 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. Providers, 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 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

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	N	Y	Y	<ul style="list-style-type: none"> ▪ Completing any claim transaction; ▪ Submitting clinical authorization requests 	N/A	N/A
Submit Standard Claim	Y	Y	Y	<ul style="list-style-type: none"> ▪ Submitting a claim for authorized, 	Within the plan’s filing limit	N/A

TRANSACTION	EDI	ESERVICES	IVR	APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
				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.	<ul style="list-style-type: none"> ▪ Claims denied for late filing may be resubmitted as reconsiderations. ▪ Rec ID is required to indicate that claim is a resubmission.
Waiver* (Request for waiver of timely filing limit) <i>Please refer to the health plan-specific addendum for your plan's filing limit)</i>	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: <ul style="list-style-type: none"> ▪ 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.	<ul style="list-style-type: none"> ▪ Waiver requests will be considered only for these 4 circumstances. A waiver request that presents a reason not listed here, will result in a claim denial on a future EOB. ▪ A claim submitted beyond the filing limit that does not meet the above criteria may be submitted as a reconsideration request.

TRANSACTION	EDI	ESERVICES	IVR	APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
				reimbursement retroactively <ul style="list-style-type: none"> ▪ Member was enrolled in health plan retroactively ▪ Services were authorized retro- actively ▪ 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. 		<ul style="list-style-type: none"> ▪ 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 plan’s filing limit.	Future EOB shows “Reconsideration Approved” or “Reconsideration Denied” with denial reason

TRANSACTION	EDI	ESERVICES	IVR	APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
Request to Void Payment	N	N	N	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ The amount paid to provider on a claim was incorrect ▪ Adjustment may be requested to correct: <ul style="list-style-type: none"> - underpayment (positive request); or - overpayment (negative request) 	<p>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.</p> <p>No filing limit applies to negative requests</p>	<ul style="list-style-type: none"> ▪ Do NOT send a refund check to Beacon. ▪ A Rec ID is required to indicate that claim is an adjustment. ▪ Adjustments are reflected on a future EOB as recoupment of the previous (incorrect) amount, and if money is owed to provider, repayment of the claim at the correct amount ▪ If an adjustment appears on an EOB and is not correct, another adjustment request may be submitted based on the previous

TRANSACTION	EDI	ESERVICES	IVR	APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
						incorrect adjustment <ul style="list-style-type: none"> 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

TABLE BLOCK #	REQUIRED?	DESCRIPTION
9d	No	Insurance Plan Name or Program Name
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: ICD 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)

TABLE BLOCK #	REQUIRED?	DESCRIPTION
24d	Yes	Procedure Code and modifier, when applicable
24e	Yes	Diagnosis 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 #
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

TABLE BLOCK #	REQUIRED?	DESCRIPTION
38	No	Untitled
39-41	Yes	Value CD/AMT (If applicable for APG claims)
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	No	Beacon Provider ID Number
52	No	Release of Information Authorization Indicator
53	No	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

TABLE BLOCK #	REQUIRED?	DESCRIPTION
63	No	Prior Authorization Number (if applicable)
64	No	RecID Number for Resubmitting a Claim
65	No	Employer Name
66	Yes	ICD Version Indicator
67	Yes	Principal Diagnosis Code
68	No	A-Q Other Diagnosis
69	No	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.
- 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

Email Contact

- Provider.relations@beaconhs.com
- EDI.Operations@beaconhs.com

Beacon Main Telephone Numbers:

You will need your practice or organization's tax ID, the member's identification number and date of birth, and the date of service. Please refer to the health plan-specific addendum for the following Beacon contact information:

- Provider Relations
- TTY
- Interactive Voice Recognition (IVR)
- Claims Hotline
- Hours of operation Monday through Friday

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.

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 (REC.ID) 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
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

BILL CLASSIFICATION (SPECIAL FACILITIES ONLY) 2ND DIGIT

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.

Provider and Member Complaint and Appeals Process

- 5.1. Complaints/Grievances
- 5.2. Clinical Appeals Process

5.1. 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 contact information at the end of this manual.

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.

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 1-2 business days of the appeal decision (time frames according to state regulation).

REQUEST FOR RECONSIDERATION OF ADVERSE DETERMINATION

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

When a reconsideration is requested, a physician advisor (PA), who has not been party to the initial adverse determination, will review the case based on the information available and will make a determination within one business day. If the member, member representative, or provider is not satisfied with the outcome of the reconsideration, he or she may file an appeal.

5.2. Clinical Appeals Process

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

When a member assigns appeal rights in writing to a participating provider, the participating provider may appeal on behalf of the member 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: (a) an initial or Level I appeal of an adverse determination for up to one hundred and eighty (180) calendar days from receipt of notice of the adverse determination; and (b) a second level or Level II appeal of an adverse determination for up to ninety (90) calendar days from receipt of notice of the Level I appeal determination, in those instances where a second level or Level II appeal is available to the member. Initial or Level I appeals may be made verbally, in writing, or via fax 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 or Level II appeals may be made verbally, in writing, or via fax transmission.

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

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

The date of the request for an initial or Level I or Level II appeal of the adverse determination is considered the date 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.

PEER REVIEW

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

URGENCY OF APPEAL PROCESSING

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

APPEALS PROCESS DETAIL

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

- Expedited Clinical Appeals
- Standard Clinical Appeals

Each table illustrates:

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

Expedited Clinical Appeals

LEVEL 1 APPEAL	LEVEL 2 APPEAL	EXTERNAL REVIEW
<p>Medicaid Members, their legal guardians, or their authorized representatives have up to 60 business days from the date of the adverse action notice to file an appeal.</p> <p>CHP Members may request an appeal within 180 calendar days from the date of the action notice.</p> <p>Medicare Members have 60 calendar days after notification of and adverse determination to file a reconsideration/appeal.</p> <p>If the member designates an authorized representative to act on his or her behalf, Beacon will attempt to obtain a signed and dated Authorization of Representative Form. Both verbal and written communication can take place with a provider who initiated the expedited appeal or with the individual who the member verbally designated as his or her representative.</p> <p>A Beacon PA, who has not been involved in the initial decision, reviews all available information and attempts to speak with the member's attending physician.</p> <p>Medicaid/CHP: A decision is made within one business day or within 72 hours of receipt of the request (whichever occurs first). Verbal notification to requesting provider within the decision timeframe. Written notification of the decision is sent to the provider and the</p>	<p>N/A</p>	<p>External reviews for Medicaid Members: Members or their representatives may request an expedited State Fair Hearing with the state office associated with the member's Medicaid plan. Please refer to the health plan-specific contact information at the end of this manual for the address and phone number of the State Fair Hearing office.</p> <p>For assistance in filing a request for a State Fair Hearing with the state office associated with the member's Medicaid plan, members or their representatives may contact Beacon's Member Services Department through the plan's dedicated phone line. Please refer to the health plan-specific contact information at the end of this manual.</p> <p>Please note, members may represent themselves or appoint someone to represent them at the fair hearing.</p> <p>Independent External Reviews with a state appointed agency are available only in cases where the health care services were:</p> <ul style="list-style-type: none"> ▪ Not medically necessary ▪ Experimental/ investigational ▪ Not different from care you can get in the plan's network ▪ Available from a participating provider who has the correct training and experience to meet your needs.

LEVEL 1 APPEAL	LEVEL 2 APPEAL	EXTERNAL REVIEW
<p>member within the decision timeframe of the appeal.</p> <p>Medicare: Resolution and notification of expedited pre-service and concurrent reconsiderations/appeals will occur within 72 hours of the date of the receipt of the reconsideration/appeal or as expeditiously as the member's condition requires.</p> <p>In the event that an expedited request is not granted because the case does not meet expedited criteria, the member will receive prompt verbal notification and also written notification that the request will be processed within the standard timeframes.</p> <p>Throughout the course of an appeal, the member shall continue to receive services without liability for services previously authorized by Beacon, as long as all of the following criteria are met:</p> <ul style="list-style-type: none"> ▪ The appeal was filed in a timely fashion ▪ The appeal involved the termination, suspension, or reduction of a previously authorized course of treatment ▪ The services were ordered by an authorized provider ▪ The original period covered by the authorization has not expired ▪ The member requested an extension of the benefits 		<p>Before requesting an external review, members must file an Internal Appeal with Beacon and get a Final Adverse Determination. If an Internal Expedited Appeal is requested with Beacon, the member may also request an Expedited External Review at the same time.</p> <p>The member and Beacon may jointly agree to skip the internal appeal process and the member may go directly to the external review.</p> <p>Members or their representatives have four months to request an External Review from receipt of a Final Adverse Determination, or from when an agreement was made to skip Beacon's Internal Appeal process. Providers appealing on their own behalf must request an External Review within 60 calendar days of the date of the adverse determination.</p>

Standard Clinical Appeals

LEVEL 1 APPEAL	LEVEL 2 APPEAL	EXTERNAL REVIEW
<p>Medicaid Members, their legal guardians, or their authorized representatives have up to 60 business days from the date of the adverse action notice to file an appeal.</p> <p>CHP Members may request an appeal within 180 calendar days from the date of the action notice.</p> <p>Medicare Members have 60 calendar days after notification of and adverse determination to file a reconsideration/appeal.</p> <p>If the member designates an Authorized Representative to act on his or her behalf, Beacon will attempt to obtain a signed and dated Authorization of Representative Form.</p> <p>Both verbal and written communication can take place with a provider who initiated the appeal or with the individual who the member verbally designated as his or her representative.</p> <p>A Beacon PA, who has not been involved in the initial decision, reviews all available information.</p> <p>Medicaid/CHP: A decision is made within two business days or 15 calendar days of initial request (whichever occurs first). Verbal notification to requesting provider within the decision timeframe.</p> <p>Written notification of the decision is sent to the provider and the member within the</p>	<p>The number of appeals available is determined by the member's benefit plan. When applicable, members or their representatives have 90 calendar days from the date of a Level I appeal determination to request a Level II appeal.</p> <p>Written Appeal Acknowledgment is sent within 15 calendar days of receipt of the request</p> <p>A decision is made within 10 business days or 15 calendar days of receipt of necessary medical records (whichever occurs first).</p> <p>Verbal notification to requesting provider within the decision timeframe.</p> <p>Written notification is sent to the provider and member within the decision timeframe.</p> <p>Contact Information: Appeal requests can be made by calling or writing to Beacon's Appeals Coordinator. Please refer to the health plan-specific addendum for contact information.</p>	<p>External reviews for Medicaid Members: Members or their representatives have 60 calendar days from the date of an initial adverse notice to request a state fair hearing.</p> <p>For assistance in filing a request for a State Fair Hearing with the state office associated with the member's Medicaid plan, members or their representatives may contact Beacon's Member Services Department through the plan's dedicated phone line. Please refer to the health plan-specific contact information at the end of this manual.</p> <p>Please note at the fair hearing, members may represent themselves or appoint someone to represent them.</p> <p>External Reviews for Commercial Members: Members or their representatives may request an external review by an Independent Review Organization. The member, representative or provider must complete Beacon's internal appeal process before requesting an external review.</p> <p>The member and Beacon may jointly agree to skip the Internal Appeal process and the member may go directly to the External Review.</p> <p>Members or their representatives have four months to request and External</p>

LEVEL 1 APPEAL	LEVEL 2 APPEAL	EXTERNAL REVIEW
<p>decision timeframe of the appeal.</p> <p>Medicare: Resolution of non-urgent reconsiderations/ appeal and written notification will occur within 30 calendar days of receipt of the request. Resolution and notification of post-service reconsiderations/ appeal will occur within 60 calendar days of receipt of the request.</p> <p>If the appeal requires review of medical records, the member's or the authorized representative's signature is required on an Authorization to Release Medical Information Form authorizing the release of medical and treatment information relevant to the appeal. If the medical record with Authorization to Release Medical Information Form is not received prior to the deadline for resolving the appeal, a resolution will be rendered based on the information available. The provider must submit the medical chart for review. If the chart is not received, a decision is based on available information.</p> <p>For Medicaid/CHP and Medicare members, the timeframes for the resolution of an appeal can be extended by 14 days if the member or his/her representative requests an extension.</p> <p>Contact Information: Expedited appeal requests can be made by calling Beacon's</p>		<p>Review from receipt of a Final Adverse Determination, or from when an agreement was made to skip Beacon's Internal Appeal process.</p> <p>The External Appeal decision will be made in 30 days. Expedited decisions are made in 72 hours. The decision will be sent in writing.</p> <p>Contact Information: For External Appeal application and instructions, Medicaid and CHP members or their representatives may:</p> <ul style="list-style-type: none"> ▪ Call Beacon; ▪ Call the New York State Department of Financial Services at 1-800-400-8882; or ▪ Go on line: www.dfs.ny.gov <p>For Medicaid Members: Please refer to the health plan-specific contact information at the end of this manual for the address and phone number of the State Fair Hearing Office.</p> <p>For Commercial Members: Please refer to the health plan-specific addendum for contact information for the address and phone number of the Independent Review Organization.</p>

LEVEL 1 APPEAL	LEVEL 2 APPEAL	EXTERNAL REVIEW
Appeals Coordinator. Please refer to the health plan-specific addendum for contact information.		

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

Communicating with Beacon

- 6.1. Transactions and Communications with Beacon
- 6.2. Electronic Media
- 6.3. Communication of Member and Provider Information
- 6.4. Beacon Provider Database
- 6.5. Member Eligibility Verification Tools

6.1. Transactions and Communications with Beacon

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

6.2. 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.beaconhealthoptions.com 24/7.

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

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

Go to <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@beaconhs.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 Copayment	Yes	Yes	Yes
Check Number of Visits Available	Yes	Yes	Yes
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.

6.3. 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.

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

TYPE OF INFORMATION	METHOD OF NOTIFICATION	
	eSERVICES	EMAIL
General Practice Information		
Change in address or telephone number of any service	No*	Yes
Addition or departure of any professional staff	No*	Yes
Change in linguistic capability, specialty, or program	No*	Yes
Discontinuation of any covered services listed in Exhibit A of provider's PSA	No*	Yes
Change in licensure or accreditation of provider or any of its professional staff	No*	Yes
Appointment Access		

TYPE OF INFORMATION	METHOD OF NOTIFICATION	
	eSERVICES	EMAIL
Change in licensure or accreditation of provider or any of its professional staff	No*	Yes
Change in hours of operation	No*	Yes
Is no longer accepting new patients	No*	Yes
Is available during limited hours or only in certain settings	No*	Yes
Has any other restrictions on treating members	No*	Yes
Is temporarily or permanently unable to meet Beacon standards for appointment access	No*	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

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

6.4. 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.

6.5. 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.

6.6. Member Eligibility Verification Tools

ONLINE	ELECTRONIC DATA INTERCHANGE (EDI)	VIA TELEPHONE
Beacon’s eServices	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)

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.

Utilization and Care Management

- 7.1. Utilization Management
- 7.2. Medical Necessity and Level of Care Criteria
- 7.3. Terms and Definitions
- 7.4. Accessibility Standards
- 7.5. Utilization Management Review Requirements
- 7.6. Care Management

7.1. Utilization Management

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

- All UM decisions are based on medical necessity
- Financial incentives based on an individual UM clinician's number of adverse determinations/adverse actions or denials of payment are prohibited
- UM decision makers do not receive financial incentives for decisions that result in underutilization
- UM cannot deny of coverage or ongoing course of care unless an appropriate alternate level of care can be identified and approved

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

7.2. Medical Necessity and Level of Care Criteria

Beacon shall perform utilization review (UR) for the determination of clinical appropriateness, level of care (LOC) and/or medical necessity to authorize payment for behavioral health services in the areas of mental health and substance use disorders. Beacon defines medically necessary services as 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's application of LOC criteria and authorization procedures represent a set of formal techniques designed to monitor the use of, and/or evaluate the medical necessity, appropriateness, efficacy, and efficiency of, behavioral health care services.

Beacon's mental health LOC criteria were developed from the comparison of national, scientific and evidenced-based criteria sets, including but not limited to, those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA) and American Academy of Child and Adolescent Psychiatry (AACAP). Beacon's substance use disorder LOC criterion is determined by the

American Society of Addiction Medicine (ASAM) or by the Level of Care for Alcohol and Drug Treatment Referral, (LOCADTR) where and when required by the New York State Office of Alcoholism and Substance Abuse (NYS OASAS). Home and Community Based Services LOC is approved by the New York State Office of Mental Health.

Beacon's mental health LOC criteria are reviewed annually, or more frequently, as necessary by the LOC Criteria Committee (which contains licensed behavioral health practitioners) and updated as needed when new treatment applications and technologies are adopted as generally accepted professional medical practice. The criteria sets are reviewed by Beacon's physician advisors (PAs), all of whom are practicing psychiatrists. New treatment applications and technologies are reviewed by the Clinical Research and Innovative Programming (CRIP) Committee, and then presented to a Provider Advisory Council for further review and recommendations. Changes recommended as a result of practitioner review are forwarded to the vice president of Medical Affairs and the LOC Committee, which makes the final determination regarding the content of the LOC criteria. After review and approval of any new or changed LOC criteria, they are updated on Beacon's participating provider webpage, as appropriate.

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

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

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

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

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

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

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

Unless otherwise specified, all admissions to inpatient mental health and substance use disorder facilities and any diversionary services require prior authorization. The decision to provide treatment or service to a member is the responsibility of the attending provider and the member (his or her patient). If the requesting provider does not provide the necessary information for Beacon to make a medical necessity determination, Beacon will make a determination based on the information received within the specified time frames, which may result in an adverse determination/action.

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

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

The requested service must also be covered by the member's benefit plan.

Beacon PAs are available at any time during the UM process to discuss by telephone adverse determinations based on medical necessity with attending physicians and other licensed practitioners. Additionally, the treating practitioner may speak with a Beacon PA at any time to discuss any LOC questions the practitioner might have. In the event the case is outside the PA's scope of practice, she/he may consult with, or refer the case to, a practitioner who has experience in treating the condition.

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

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

Beacon does not routinely request copies of medical records related to behavioral health treatment requests that are in prospective or concurrent review. Additional medical records will only be requested when there is difficulty in making a decision. Written authorization for release of health information is not required for routine health care delivery options. To avoid duplicative requests for information from members or providers, the original requestor of information will ensure all appropriate clinical and administrative staff receives the necessary clinical and demographic information. Practitioners/providers

are required by the 2002 Standards for Privacy of Individually Identifiable Health Information (the Privacy Rule), to make a good-faith effort to obtain a patient's written acknowledgement of receipt of privacy rights and practices. Written consent for release of health information is not required for routine health care delivery options. When a provider is acting on behalf of a member, written consent from a member to release his/her record is preferred.

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

For authorization decisions not reached within the time frames specified, a notice is mailed on the day the time frame expires or within 24 hours upon notification by the member or provider that one of the time frames was not met.

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

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

7.3. Terms and Definitions

UTILIZATION MANAGEMENT (UM)

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

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

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

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

ADVERSE ACTION/DETERMINATION

The following actions or inactions by the organization:

1. Failure to provide covered services in a timely manner in accordance with the waiting time standards

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

EMERGENCY SERVICES

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

MEMBER

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

NON-URGENT (STANDARD) CONCURRENT REVIEW DECISIONS

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

NON-URGENT (STANDARD) PRE-SERVICE DECISIONS

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

PEER REVIEW CONVERSATION

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

POST-SERVICE REVIEW AND DECISIONS

Any review for care or services that have already been received. A post-service decision would authorize, modify or deny payment for a completed course of treatment where a pre-service decision was not

rendered, based on the information that would have been available at the time of a pre service review and treatment stay, also known as retrospective decisions.

URGENT CARE REQUESTS

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

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

URGENT (EXPEDITED) CONCURRENT REVIEW DECISIONS

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

URGENT (EXPEDITED) PRE-SERVICE DECISIONS

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

7.4. Accessibility Standards

APPOINTMENT STANDARDS

TYPE OF APPOINTMENT/ SERVICE	APPOINTMENT ACCESS TIMEFRAMES AND EXPECTATIONS
General Appointment Standards	
Routine/Non-Urgent	Within 14 calendar days
Urgent Care	Within 24 hours
Emergency Services	Immediately; 24 hours a day, 7 days per week

SERVICE AVAILABILITY

SERVICE AVAILABILITY	HOURS OF OPERATION
On-Call	<ul style="list-style-type: none"> ▪ 24-hour on-call services for all members in treatment

SERVICE AVAILABILITY	HOURS OF OPERATION
	<ul style="list-style-type: none"> Ensure that all members in treatment are aware of how to contact the treating or covering provider after hours and during provider vacations
Crisis Intervention	<ul style="list-style-type: none"> Services must be available 24 hours per day, 7 days per week Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician, agency affiliated staff, crisis team, or hospital emergency room
Outpatient Services	<ul style="list-style-type: none"> Outpatient providers should have services available Monday through Friday, from 8 a.m. to 5 p.m., CST at a minimum Evening and/or weekend hours should also be available at least 2 days per week
Interpreter Services	<ul style="list-style-type: none"> Under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency

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

7.5. Utilization Management Review Requirements

INPATIENT AND DIVERSIONARY

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.

PRE-SERVICE REVIEW	CONTINUED STAY (CONCURRENT REVIEW)	POST-SERVICE REVIEW
The facility clinician making the request needs the following	To conduct a continued stay review, call a Beacon UR	Post-service reviews may be conducted for inpatient, diversionary or outpatient services rendered when

PRE-SERVICE REVIEW	CONTINUED STAY (CONCURRENT REVIEW)	POST-SERVICE REVIEW
<p>information for a pre-service review:</p> <ul style="list-style-type: none"> ▪ Member's health plan identification number ▪ Member's name, gender, date of birth, and city or town of residence ▪ Admitting facility name and date of admission ▪ ICD or DSM diagnosis: (A provisional diagnosis is acceptable.) ▪ Description of precipitating event and current symptoms requiring inpatient psychiatric care ▪ Medication history ▪ Substance abuse history ▪ Prior hospitalizations and psychiatric treatment ▪ Member's and family's general medical and social history ▪ Recommended treatment plan relating to admitting symptoms and the member's anticipated response to treatment ▪ Recommended discharge plan following end of requested service 	<p>clinician with the following required information:</p> <ul style="list-style-type: none"> ▪ 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.) 	<p>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.</p>

EMERGENCY PRESCRIPTION SUPPLY

Beacon does not authorize or pay claims for medications including medications used for Behavioral Health. Please contact the health plan for further information on pharmacy benefits.

For prescribers, a 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization is not available. This applies to all drugs requiring a prior

authorization, either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

A seven-day emergency supply of supply of a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization is also available.

7.6. 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.

Quality Management and Improvement Program

- 8.1. Quality Management/Improvement Program Overview
- 8.2. Provider Role
- 8.3. Quality Monitoring
- 8.4. Treatment Records
- 8.5. Performance Standards and Measures
- 8.6. Practice Guidelines and Evidence-Based Practices
- 8.7. Outcomes Measurement
- 8.8. Communication between Outpatient Behavioral Health Providers and PCPs, Other Treaters
- 8.9. Communication between Inpatient/Diversionary Providers and PCPs, Other Outpatient Treaters
- 8.10. Reportable Incidents and Events
- 8.11. Provider Responsibilities

8.1. 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

8.2. 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 Advisory Council, email provider.relations@beaconhs.com.

8.3. 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.

8.4. 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 Beacon’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 record, 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 issues 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.

8.5. 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

8.6. 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 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@beaconhs.com.

8.7. 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.

8.8. 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.

8.9. Communication between Inpatient/Diversionsary Providers and PCPs, Other Outpatient Treating

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 discharge 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.

Routine outpatient behavioral health treatment by an out-of-network provider is not an authorized service covered by Beacon. 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 60 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.

8.10. 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 781-496-4700. 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.

8.11.Provider Responsibilities

MEMBERS DISCHARGED FROM INPATIENT PSYCHIATRIC FACILITIES

Beacon requires that all members receiving inpatient psychiatric services must be scheduled for outpatient 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 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.

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@beaconhs.com of any change of address, telephone number, group affiliation, etc.

1.1. Health Plan-Specific Contact Addendum

HEALTH PLAN INFORMATION

Health plan name: MVP Health Care

Health plan EDI code: Payor ID: 43324 | Plan ID:4

BEACON CONTACT INFORMATION

Beacon hours of operation: Monday - Friday
8:00 A.M. - 8:00 P.M

Beacon Ombudsperson: 1-844-265-7586

Beacon TTY: 1-866-727-9441

Beacon's Member Services:

Medicaid and CHP Members: 1-800-852-7826

Essential Plan Members: 1-88-723-7967

Beacon Provider Relations: 1-844-265-7592

Beacon Clinical Appeals Coordinator phone number:

Medicaid and CHP Members: 1-800-852-7826

Essential Plan Members: 1-888-723-7967

Beacon Claims Department: 1-888-249-0478

Beacon Health Strategies

Claims Department

500 Unicorn Park Drive

Woburn, MA 01801

CLAIMS TIMING INFORMATION

Plan/state required filing notice filing limit: Within 120 days of the dates of service

Time limits for filing inpatient claims: Within 120 days of the date of discharge on inpatient claims

Time limits for filing outpatient claims: Within 120 days of the date of discharge on outpatient claim

Number of days for fair hearing decisions: Medicaid Members have 60 days to request Fair Hearing from the date of the denial notice. Determination will be made within 30 days from the date the request was received

GOVERNMENT CONTACT INFORMATION

State Fair Hearing Office

NYS Office of Temporary and Disability
Assistance

Office of Administrative Hearings

Managed Care Hearing Unit

P.O. Box 22023

Albany, New York 12201-2023

www.otda.state.ny.us/oah

State Independent Review Organization

New York State Department of Financial
Services

P.O. Box 7209

Albany, New York 12224-0209

Phone number: 1-800-400-8882

externalappealquestions@dfs.ny.gov

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

Centers for Medicare & Medicaid Services

Centers for Medicare & Medicaid Services

7500 Security Boulevard

Baltimore, Maryland 21244-1850

1-800-MEDICARE (1-800-633-4227)

TTY: 1-877-486-2048