



Beacon Health Options

Provider Handbook

www.beaconhealthoptions.com/providers/beacon/

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Appendix 1: [Handbook Glossary](#)

Appendix 2: List of Forms and Reference Documents

- [Medical Necessity Criteria](#)
- [Clinical Practice Guidelines](#)
- [Resource Documents](#)

Appendix 3: [State/Government Program/Network Specific Provision and/or Supplements](#)

Appendix 4: [Medicare Advantage Specific Provisions](#)

Appendix 4A: [New York State Specific – Medicare Advantage/Medicare-Medicaid Dual Eligible Required Provisions \(Fully Integrated Duals Advantage \(FIDA\)\)](#)

Appendix 5: [EAP Handbook](#)

Appendix 5A: [MOS Handbook](#)

1. INTRODUCTION

1.01 Overview

Welcome to Beacon's¹² network of *participating providers*. This *handbook* is an extension of the *provider agreement* and includes requirements for doing business with Beacon Health Options, Inc. and its affiliates and subsidiaries, including *policies and procedures* for individual providers, affiliates, group practices, programs, and facilities.

Together, the *provider agreement*, addenda, and this *handbook* outline the requirements and procedures applicable to *participating providers* in the Beacon network(s).

Italicized terms are terms included in the Glossary section of this *handbook* located in **Appendix 1**.

Forms referenced in this *handbook* or in the *provider agreement* are available for download or printing through the 'Beacon Health Options Providers' section of the *website*.

Important Notice: Except to the extent a given section or provision in this *handbook* is included to address a regulatory, *accreditation*, or government program requirement or specific benefit plan requirement, in the event of a conflict between a *member's* benefit plan, the *provider agreement*, and this *handbook*, such conflict will be resolved by giving precedence in the following order:

1. The *member's* benefit plan
2. The *provider agreement*
3. This *handbook*

This *handbook* replaces in its entirety any previous version and is available electronically on the *website*.

Changes and updates to this *handbook*, *member* educational materials, news, and other online services are posted and/or available through the 'Beacon Health Options Providers' section of the *website*. Changes and updates become binding 60 days after notice is provided by mail or electronic means, or such other time as may be identified for compliance with statutory, regulatory, and/or *accreditation* requirements to which Beacon is or may be subject.

Links to the *website*, other information, and forms referenced throughout this *handbook* are included for convenience purposes only and such information and/or forms are subject to change without notice. *Participating providers* should access and download the most up-to-date information and/or forms from the *website* at the time needed.

Questions, comments, and suggestions regarding this *handbook* should be directed to:

Beacon Health Options
National Provider Service Line
800-397-1630
Mon. through Fri., 8 a.m. to 8 p.m. ET

¹ Any use of or reference to "Beacon" or to "Beacon Health Options" in any communication, publication, notice, disclosure, mailing or other document, whether written or electronic, requires the prior written *authorization* of Beacon.

² This *handbook* applies to *participating providers* in provider network(s) maintained by Beacon Health Options, Inc. and the following subsidiaries: Beacon Health of California, Inc.; ValueOptions of Kansas, Inc.; and CHCS IPA, Inc. CHCS IPA, Inc. is an independent practice association operating only in New York and is a wholly owned subsidiary of Beacon Health Options, Inc.

1.02 About Beacon

While Beacon Health Options, Inc. is licensed in numerous states as a third-party administrator and/or utilization review agent of behavioral health services, some of Beacon Health Options, Inc.'s affiliates and subsidiaries are licensed as full service or limited service health plans operating in a designated state. Beacon Health Options of California, Inc., ValueOptions of Kansas, Inc., CHCS IPA, Inc., are all subsidiaries of Beacon Health Options, Inc. For purposes of this handbook, references to "Beacon" shall mean, individually or collectively, as applicable, the Beacon legal entity with whom the *provider* has contracted to provide services with respect to a *member*.

Beacon, through contracts with clients, manages and/or administers behavioral health and wellness benefits and services, including employee assistance programs (EAP), work/life services, wellness programs, and mental health and substance use disorder benefits and services in a wide array of settings. Today, clients include employer groups, commercial/exchange health plans, *Medicare Advantage* and managed *Medicaid* health plans, and state and local government programs and agencies. Additional information about Beacon is available on the *website*.

Beacon manages mental health and substance use disorder services of benefit plans sponsored and/or administered, in whole or in part, by companies and organizations contracted with Beacon in compliance with applicable laws, rules, and regulations, including without limitation the Federal Mental Health Parity and Addictions Equity Act, Affordable Care Act, state parity laws, and regulations. Subject to benefit plan requirements, inpatient *covered services* and other higher *levels of care* generally require prior *authorization/certification* or *notification* of the admission. Outpatient *covered services* are reviewed for medical necessity when clinical factors indicate possible non-evidenced based practice or the need for additional interventions. Certain high-risk or complex cases may require prior review and/or more intensive review and/or case management. Details of individual benefit plan requirements and procedures are available through *ProviderConnect*, Beacon's secure, HIPAA-compliant website designed specifically for providers.

Beacon's mission is to help people live their lives to the fullest potential. Our values guide the way we treat our members, providers, clients, and each other. They are the heart of all we do. A number of Beacon's regions or Engagement Centers sponsor consumer self-help groups, educational programs, drop-in centers, advocacy programs, and other consumer-led activities that help people become actively involved in achieving their highest possible level of functioning in their communities.

Beacon arranges for the provision of and access to a broad scope of behavioral health services for *members* through its provider networks, consisting of appropriately licensed and/or certified practitioners, facilities, providers, and programs offering varying *levels of service*.

- Beacon does not specifically offer rewards or incentives, financial or otherwise, to its *utilization management* staff, contractors, *participating providers*, *Clinical Care Managers (CCMs)*, *Peer Advisors*, or any other individuals or entities involved in making *medical necessity* determinations for issuing denials of coverage or service or that are intended to encourage determinations that result in underutilization. *Utilization management* decisions are based solely on appropriateness of care and service, existence of coverage and utilizing the medical necessity criteria approved for use by Beacon.

Information specific to *participating providers* in *EAP* networks is located in **Appendix 5** on the *website*.

Contact information for Beacon is located in this *handbook*. Additional information about the locations, email addresses, and toll-free numbers of Beacon's offices throughout the country are conveniently located on the *website*.

1.03 Contact Information

<p>Administrative Appeal</p>	<p>To request an <i>administrative appeal</i>, call the toll-free number included in the administrative denial letter received.</p>
<p>Potential Quality of Care (PQOC) Concerns</p>	<p>Report all <i>Potential Quality of Care Concerns (PQOC)</i> to Beacon immediately and within 24 hours using the clinical form available on Beacon’s website at https://www.beaconhealthoptions.com/providers/beacon/forms/clinical-forms/ or follow local notification processes when applicable.</p>
<p>Changing your Provider Profile (e.g., name, address)</p>	<p>To change or update your Provider Profile (e.g., address), the preferred method to do so is through the “Update Demographic Information” option in <i>ProviderConnect</i>.</p> <p>Providers without access to <i>ProviderConnect</i> can call Beacon’s National Provider Service Line at 800-397-1630, Mon. through Fri., 8 a.m. to 8 p.m. ET.</p> <p>Note: Updating a Tax ID requires an accompanying <i>W-9</i> form, which can be uploaded as an attachment in <i>ProviderConnect</i>. A copy of the <i>W-9</i> form is available on the <i>website</i>.</p>
<p>Claims</p>	<p>For general claim inquires, call 800-888-3944.</p> <p>For technical questions related to direct claim submission via <i>ProviderConnect</i> or batch submission, please contact the <i>EDI</i> Helpdesk at:</p> <ul style="list-style-type: none"> ▪ Telephone: 888-247-9311 from 8 a.m.-6 p.m. ET ▪ Fax: 866-698-6032 ▪ Email: e-supportservices@beaconhealthoptions.com <p><i>For providers who are unable to submit a claim electronically, paper claims should be sent to the address referenced on the member’s benefit plan, as addresses may vary.</i></p> <p>Beacon Health Options’ Payer ID is BEACON963116116.</p>
<p>Clinical Appeals</p>	<p>To request a <i>clinical appeal</i> on a <i>member’s</i> behalf, call the toll-free number included in the adverse determination letter received.</p>
<p>Complaints/Grievances</p>	<p>To file a <i>complaint/grievance</i>, call the toll-free number on the <i>member’s</i> identification card to speak to customer service.</p>
<p>Credentialing</p>	<p>To obtain information pertaining to network participation status, contact Beacon’s National Provider Service Line at 800-397-1630 Mon. through Fri., 8 a.m. to 8 p.m. ET.</p>

	To send supporting documentation such as malpractice or insurance cover sheets, please fax to 866-612-7795.
Fraud and Abuse	<p>Report questionable billing practices or suspected <i>fraud</i> to:</p> <p>Beacon Health Options, Inc. ATTN: Corporate SIU 1400 Crossways Blvd, Ste 101 Chesapeake, VA 23320</p> <p>SIU@beaconhealthoptions.com</p> <p>Beacon’s National Provider Service Line at 800-397-1630, Mon. through Fri., 8 a.m. to 8 p.m. ET.</p>
Member Benefits, Eligibility, and Authorizations	<p>For questions about <i>member</i> eligibility or benefits, providers can submit an inquiry via <i>ProviderConnect</i> by selecting “Eligibility and Benefits.” For questions about <i>authorization</i> status, providers can select the “Review an <i>Authorization</i>” option via <i>ProviderConnect</i>.</p> <p><i>For additional questions about authorizations or benefits, call the toll-free number on the back of the member’s identification card.</i></p>
Member Customer Service	To reach <i>member</i> customer service, call the toll-free number on the back of the <i>member’s</i> identification card.
Provider Coverage During Absences	To update Beacon if there will be lack of provider coverage due to absences (e.g., coverage while on vacation), contact the <i>CCM</i> with whom the <i>participating provider</i> conducts reviews during absences, or call the number on the <i>member’s</i> card to provide coverage information.

2. E-COMMERCE INITIATIVE

Providers in the Beacon network are encouraged to conduct all routine transactions electronically, including:

- Submission of claims
- Submission of *authorization* requests
- Verification of eligibility inquiries
- Submission of re-credentialing applications
- Updating of provider information
- Electronic fund transfer/direct deposit through PaySpan®
- Provider claims and *authorization* status checks
- Reviewing claims remittance information

To conduct these transactions referenced above, Beacon encourages providers to utilize the resources detailed further in the handbook sections titled “Electronic Resources,” “Claim Procedures,” “Re-

credentialing and Credentialing” and “Updating Provider Information.” These resources will expedite claims processing and facilitate administrative tasks.

For questions or further assistance regarding this recommendation, please email your Regional Provider Relations team or call the Beacon National Provider Service Line at 800-397-1630 Monday through Friday, 8 a.m. to 8 p.m. ET. Regional Office email addresses are located under “Contact Information” on the website.

3. ELECTRONIC RESOURCES

The following electronic solutions are available to assist providers in complying with Beacon’s *E-Commerce* initiative:

3.01 CAQH

All *participating providers* are encouraged to register and participate with CAQH®, including attesting on a regular basis, to reduce the credentialing timeline and improve directory accuracy. CAQH is an industry standard solution to capture and share health care self-reported information that 1.4 million health care providers use today—97 percent of Beacon’s individual providers are already registered. Beacon accesses information from CAQH as updates are made to provider data. Be sure to give “Beacon Health Options” permission to access CAQH content.

3.02 ProviderConnect

ProviderConnect is a secure, password-protected portal where *participating providers* conduct certain online activities with Beacon directly 24 hours a day, seven days a week (excluding scheduled maintenance and unforeseen systems issues). Currently, *participating providers* are provided with access to the following online activities:

- *Authorization or certification* requests for all levels of care
- *Concurrent review* requests and discharge reporting
- Single and multiple electronic claims submission
- Claim status review for both paper and electronic claims submitted to Beacon
- Verification of eligibility status
- Submission of inquiries to Beacon’s provider customer service
- Updates to practice profiles/records
- Electronic access to *authorization/certification* letters from Beacon
- *Provider summary vouchers (PSVs)*

Links to information and documents important to *providers* are located on the ProviderConnect page of our website.

Note: Use of *E-Commerce* solutions offered by Beacon is recommended.

3.03 Electronic Claim Submission and Clearinghouses

Electronic claim submission is also accepted through clearinghouses or batch submission directly to Beacon. Submitters must reference the Beacon Health Options' Payer ID, **Beacon963116116**, to ensure Beacon receives those claims. The provider must register for online services and submit the appropriate EDI form to be linked with the clearinghouse.

For information about testing and setup for EDI, review Beacon's 837 companion guide available on Beacon's website. Beacon accepts standard HIPAA 837 professional and institutional health care claim transactions and provides 999 and 277CA response.

3.04 Payspan

Beacon *providers/participating providers* must use Payspan for electronic fund transfer. Payspan enables providers to receive payments automatically in their bank account of choice, receive email notifications immediately upon payment, view remittance advices online, and download an 835 file to use for auto-posting purposes.

3.05 Beaconhealthoptions.com

Beacon's website, www.beaconhealthoptions.com contains information about Beacon and its business. Links to information and documents important to *providers* are located in the 'Beacon Health Options Providers' section, including additional information pertaining to Beacon's *E-Commerce* Initiative.

Access to this handbook is available on the *website* as well.

Beacon's Privacy Policy is located on the *website*.

Note: The *website* Privacy Policy, including but not limited to limitations on liability and warranties, apply to the installation and use of, and any technical assistance related to the installation or use of this software. Technical assistance includes but is not limited to any guidance, recommendations, instructions, or actions taken by Beacon or its employees, including where such activity is performed directly on your system, device, or equipment by a Beacon employee or other representative.

3.06 Achieve Solutions

Achieve Solutions is Beacon's educational behavioral health and wellness information website. As this website is educational in nature, it is not intended as a resource for emergency crisis situations or as a replacement for medical care or counseling. The website includes self-management tools and other resources that can support members.

When members can self-identify risk factors or health issues early on, they can proactively take steps to improve their health and reduce potential risk factors. Offering self-management tools encourages members to monitor, track, and take charge of their own behavioral and/or physical health conditions.

Beacon offers member-specific self-management tools and educational content on its **Achieve Solutions platform**, which you can find on the **Beacon Health Options website under Member Health Tools**.

Topics include (but are not limited to):

- Adult BMI Calculator
- Reducing High-Risk Drinking
- Increasing Physical Activity
- Integrated Care: Taking Charge of Your Health
- Do You Have a Nicotine Addiction?
- Are Your Weight Management Habits Healthy?

- Managing Stress in Your Life
- Identifying Common Emotional Concerns
- How Well Do You Bounce Back from Life's Challenges?

We encourage you to promote the use of this award-winning website with the individuals you serve.

3.07 eServices

eServices is a secure, password-protected portal used by certain health plans contracted with Beacon. *Participating providers* using this portal can conduct certain online activities with Beacon directly 24 hours a day, seven days a week (excluding scheduled maintenance and unforeseen systems issues). Currently, *participating providers* are provided with access to the following online activities:

- Submit claims
- Check real-time claim status
- Print explanation of benefit (EOB) information
- Check member eligibility
- Check initial encounters used
- Request authorizations
- Check the status of authorizations, including units used
- Update practice and clinician information
- View or print provider documents such as manuals, forms, or bulletins
- Generate and print reports

eServices transactions take less time to complete than paper submissions, enabling providers to improve productivity. Fax transmission problems, mail delays, and most errors are eliminated by using eServices, thereby reducing provider administrative staff burden.

Links to information and documents important to providers are located on the eServices page of our website.

3.08 Communications

Beacon regularly communicates with *participating providers* via email. Communications include regulatory requirements, protocol changes, helpful reminders regarding claim submission, and other topics. To receive communications in the most efficient manner, we strongly encourage providers to maintain accurate contact information, especially valid email addresses, on file with Beacon.

Beacon uses email encryption when communicating *protected health information* (PHI) and personally identifiable information (PII). If *provider/participating provider* does not use email encryption, Beacon recommends sending PHI or PII to Beacon through our provider portals or by secure fax. Be aware: It is a HIPAA violation to include any member identifying information or PHI in non-secure email through the Internet.

4. PARTICIPATING PROVIDERS

Beacon does not refuse to contract or terminate existing contractual relationships with *providers* because a provider:

- Advocates on behalf of a *member*
- Files a *complaint* with or against Beacon
- *Appeals* a decision or determination made by Beacon

Participating providers are independent contractors of Beacon. This means that *participating providers* practice and operate independently, are not employees of Beacon, and are not partners with or involved in a joint venture or similar arrangement with Beacon. Beacon does not direct, control, or endorse health care or treatment rendered or to be rendered by *providers* or *participating providers*.

Beacon encourages *participating providers/providers* to communicate with *members* to discuss available treatment options, including medications and available options, regardless of coverage determinations made to or to be made by Beacon or a designee of Beacon. Treating *providers*, in conjunction with the *member* (or the *member's* legal representative), make decisions regarding what services and treatment are rendered. Any *preauthorization, certification, or medical necessity* determinations by Beacon relate solely to payment. *Participating providers/providers* should direct *members* to Beacon or their respective benefit plan representatives for questions regarding coverage or limitations of coverage under their benefit plan prior to rendering *non-emergency* services.

4.01 Beacon Provider Identification Numbers

The Beacon *provider number* is a *provider's/participating provider's* unique number assigned by Beacon. Some contracts will assign a *provider number* specific to that contract that includes an alpha prefix. The *provider number* identifies a provider in the Beacon system and is used for giving access to ProviderConnect. The *provider number* is on file with Beacon. *Providers/participating providers* should contact the Beacon National Provider Services Line at 800-397-1630, Mon. through Fri., 8 a.m. to 8 p.m. ET for questions regarding Provider Identification Numbers and/or for assistance in obtaining a Provider Identification Number.

The *provider's* service location vendor number is a number that identifies where services are or were rendered. A *participating provider* may have multiple vendor locations and each vendor location is given a five-digit number preceded by a letter (e.g., A23456, D45678).

The *pay-to vendor number* is a vendor number issued by Beacon and indicates the mailing address for all payments and also when using our electronic payments service through PaySpan. A provider can have more than one pay-to vendor number and each number needs to be registered with PaySpan.

The *National Provider Identifier (NPI)* is a unique 10-digit identification number issued to health care providers in the United States by the *Centers for Medicare and Medicaid Services (CMS)*. The *NPI* is different from a Beacon-assigned *provider number*. The *NPI* is a single provider identifier that replaces the different identifiers used in standard electronic transactions. *HHS* adopted the *NPI* as a provision of *HIPAA*. This number is also contained in the Beacon system and can be used to locate a provider record for claims, referrals, and *authorization* purposes.

4.02 Provider Satisfaction Survey

Beacon conducts an annual provider satisfaction survey to measure *participating providers'* opinions regarding Beacon's clinical and administrative processes. Data is aggregated, trended, and used to identify improvement opportunities. Results are reviewed with the Executive Leadership Team (ELT), Corporate Quality Committee (CQC), Quality Leads, Provider Relations Leads, and Provider Quality Management. A formal written improvement plan is developed by Beacon to identify and act on improvement opportunities. Departments and regions work in collaboration with the national network/provider relations team on improvement activities.

4.03 Changes to Beacon Provider Records

Information about *participating providers'* physical addresses and locations, billing addresses, hours of operation, clinical specialties, and licensure or certification status are used in credentialing and re-credentialing activities as well as in provider directories and listings made available to clients and *members*. *Participating providers* must notify Beacon in advance of changes or updates to information provided to Beacon.

Changes and updates to *participating provider* information and records should be submitted to Beacon via ProviderConnect. If changes to a Tax ID are necessary, there is a W-9 form accessible through the *website*.

At the time of recredentialing, *participating providers* should make changes to information previously submitted to Beacon and contained in their Beacon Provider Record through ProviderConnect or *CAQH*.

Failure to report changes in a timely manner can adversely affect participation in the network and may result in delayed claims payments.

4.04 Policies and Procedures

Pursuant to the terms of the *provider agreement*, *participating providers* must comply with Beacon's *policies and procedures* and as outlined in this *handbook*. Certain *policies and procedures* may apply only to a designated line of business or type of benefit plan or government sponsored health benefit program; a list of these is located in **Appendix 3**.

The *CMS* requires *Medicare Advantage* plans to include certain terms and provisions in *provider agreements* and in *policies and procedures*. **Appendix 4** includes references to specific regulatory requirements and guidelines about participation in networks available to *Medicare Advantage* plans.

As more specifically detailed in other parts of this *handbook*, Beacon maintains *continuous quality improvement* and *utilization management* programs that include *policies and procedures* and measures designed to provide for ongoing monitoring and evaluation of services rendered to *members* (e.g., clinical review criteria, *member* and *participating provider* surveys, evaluations, and audits). *Participating provider* involvement is an integral part of these programs. *Participating providers* must cooperate with and participate in Beacon's *quality improvement* and *utilization management* programs and activities. Refusal to cooperate with Beacon's *quality improvement* and/or *utilization management* activities may adversely affect continued network participation status or result in sanctions up to and including termination of network participation status.

In addition, some Beacon clients establish procedures and requirements unique to benefit plans offered or administered by that client or to a specific government health benefit program. Therefore, in addition to careful review of the information provided in this *handbook*, it is very important to review any client and/or network specific requirements located in the 'Beacon Health Options Providers' section of the *website*.

Detailed information about a specific *member's* benefit plan requirements can be obtained by viewing a *member's* benefits on the 'Benefit' tab in ProviderConnect.

5. CREDENTIALING AND RE-CREDENTIALING

Beacon's credentialing processes for new *providers* seeking to contract with Beacon and re-credentialing processes for *participating providers* currently contracted with Beacon are designed to comply with national *accreditation* standards to which Beacon is or may be subject, as well as applicable state and/or federal laws, rules, and regulations. Credentialing and re-credentialing is required for all *providers* and *participating providers*, respectively, including without limitation individual practitioners and organizations (clinics, facilities, or programs). All *provider/participating provider* office or facility locations where services are rendered and that share the same federal tax identification number that are identified in credentialing/re-credentialing applications will be considered for participation status under that application.

Providers and *participating providers* are credentialed and re-credentialed, respectively, for participation status for designated services, level(s) of services and practice sites. Should *participating providers* have other or additional services, levels of services or practice sites available, additional credentialing and/or re-credentialing may be necessary prior to designation as a '*participating provider*' for such additional services, levels of services or practice sites. Services, levels of services or practice sites for which a *participating provider* is not credentialed for are subject to all applicable out-of-network *authorization, certification, and any benefit or coverage limitations* under the *member's* benefit plan.

As provided for in Beacon's *policies and procedures*, decisions to approve or decline initial credentialing applications, to approve re-credentialing applications, and/or to submit a given credentialing or re-credentialing application for further review are made by the Beacon Health Options *National Credentialing Committee (NCC)*, or where applicable by a local Beacon established credentialing committee.

Participating providers have the right to:

- Request review of information submitted in support of credentialing or re-credentialing applications
- Correct erroneous information collected during the credentialing or re-credentialing processes
- Request information about the status of credentialing or re-credentialing applications

All requests to review information must be submitted in writing. Verbal requests for the status of a credentialing or re-credentialing application can be made by calling the Beacon National Provider Services Line at 800-397-1630, Mon. through Fri., 8 a.m. to 8 p.m. ET. Regardless of the above, Beacon will not release information obtained through the primary source verification process where prohibited by applicable state and/or federal laws, rules, and/or regulations.

5.01 Credentialing

Initial credentialing processes begin with submission of completed and signed applications, along with all required supporting documentation using one of the following methods:

- After completing the online universal credentialing process offered by the Council for Affordable Quality Healthcare (*CAQH*), give Beacon access to your credentialing information and ensure a current attestation. Call the *CAQH* Help Desk at 888-599-1771 for answers to your questions related to the *CAQH* application or website.
- Complete a Beacon paper or online application by calling the Beacon National Provider Services Line at 800-397-1630.

This includes without limitation attestation as to:

- Any limits on the *provider's* ability to perform essential functions of their position or operational status
- With respect to individual practitioner *providers*, the absence of any current illegal substance or drug use
- Any loss of required state licensure and/or certification
- Absence of felony convictions
- With respect to individual practitioner *providers*, any loss or limitation of privileges or disciplinary action
- The correctness and completeness of the application

Failure of a *provider* to submit a complete and signed credentialing application, and all required supporting documentation timely and as provided for in the credentialing application and/or requests from Beacon, may result in rejection of request for participation status with Beacon.

Once the *participating provider* has been approved for credentialing and contracted with Beacon as an individual practitioner, group member, or facility, Beacon will advise of the effective date for specified lines of business.

Once the facility has been approved for credentialing and contracted with Beacon, all licensed or certified behavioral health professionals listed may treat members for applicable services and lines of business. The credentialed facility is responsible for credentialing and overseeing its clinical staff as Beacon does not individually credential facility-based staff.

5.02 Re-Credentialing

Re-credentialing for *participating providers* is required every three years, or such shorter period of time where required by a specific state law or regulation. The process for re-credentialing begins approximately three months prior to the end of the initial credentialing cycle or the preceding re-credentialing cycle, as applicable, and can be accomplished using one of the following methods:

- After completing the online universal credentialing process offered by the *Council for Affordable Quality Healthcare (CAQH)*, give Beacon access to your credentialing information and ensure a current attestation. Call the *CAQH* Help Desk at 888-599-1771 for answers to your questions related to the *CAQH* application or website.
- We will mail a re-credentialing application via USPS to the *participating provider* or notify the *participating provider* via email, voicemail, or fax that their online re-credentialing application is available via *ProviderConnect*.

Required documentation includes without limitation attestation as to

- Any limits on the *participating provider's* ability to perform essential functions of their position or operational status
- With respect to individual practitioner *participating providers*, the absence of any current illegal substance or drug use
- The correctness and completeness of the application (including without limitation identification of any changes in or updates to information submitted during initial credentialing)

Failure of a *participating provider* to submit a complete and signed re-credentialing application, including all required supporting documentation timely and as provided for in the re-credentialing application and/or requests from Beacon, may result in termination of participation status with Beacon and members are transitioned to in-network providers. Such *providers* may be required to go through the initial credentialing process.

5.03 Standards

Standards applicable to *providers* in the initial credentialing process and to *participating providers* in the re-credentialing process include, but are not limited to the following:

- Current, unencumbered (not subject to probation, suspension, supervision and/or other monitoring requirements), and valid license to practice as an independent provider at the highest level certified or approved by the state or states in which services are performed for the *provider's/participating provider's specialty* (individual practitioners)
- Current, unencumbered (not subject to probation, suspension, supervision and/or other monitoring requirements), and valid license to practice and/or operate independently at the highest level certified or approved by the state or states in which services are performed for the *provider's/participating provider's facility/program status* (organizations)
- *Accreditation* currently accepted by Beacon for organizations* (currently TJC, CARF, COA, HFAP, AAAHC, NIAHO, CHAP, and AOA)
- Clinical privileges in good standing at the institution designated as the primary admitting facility, with no limitations placed on the ability to independently practice in his/her specialty (individual practitioners)
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline, or licensure (individual practitioners)
- Current specialty board certification, if indicated on the application (individual practitioners)
- A copy of a current Drug Enforcement Agency (DEA) certificate and/or Controlled Dangerous Substance (CDS) Certificate where applicable (individual practitioners)
- No adverse professional liability claims which result in settlements or judgments paid by or on behalf of the *provider/participating provider* which disclose an instance of, or pattern of, behavior which may endanger *members*
- Good standing with state and federal authorities and programs (organizations)
- No exclusion or sanctions from government-sponsored health benefit programs (e.g., Medicare/Medicaid) (individual practitioners and organizations)
- Current specialized training as required for certain levels or areas of specialty care (individual practitioners)
- Malpractice and/or professional liability coverage in amounts consistent with Beacon's *policies and procedures* (individual practitioners and organizations)
- An appropriate work history for the *provider's/participating provider's specialty* (individual practitioners)

* Structured site visits are required for all unaccredited organizations.

Changes or updates to any of the above noted information is subject to re-verification from primary sources during the re-credentialing process, or at the time of notice of such a change or update from the *participating provider*. Additionally, *providers/participating providers* must have:

- No adverse record of failure to follow Beacon's *policies and procedures* or quality management activities
- No adverse record of provider actions that violate the terms of the *provider agreement*
- No adverse record of indictment, arrest or conviction of any felony or any crime indicating potential or actual *member* endangerment
- No criminal charges filed relating to the *participating provider's* ability to render services to *members*
- No action or inaction taken by *participating provider* that, in the sole discretion of Beacon, results or may result in a threat to the health or well-being of a *member* or is not in the *member's* best interest

5.04 Site Visits

In addition, and as part of credentialing or re-credentialing, Beacon may conduct a structured site visit of *provider's/participating provider's* offices/locations. Site visits include, but may not be limited to, an evaluation using the Beacon site and operations standards and an evaluation of clinical recordkeeping practices against Beacon's standards.

The current Beacon site visit tool is available for review on the *website*. As the site visit tool is subject to modification without notice, *participating providers* are encouraged to check the *website* for the most current site visit tool prior to scheduled site visits. While Beacon, at its discretion, may require a site visit in the course of credentialing and/or re-credentialing processes based on information submitted and/or obtained in the process, site visits will be conducted for *providers/participating providers* in the following categories:

- Unaccredited organizations
- Site visits required by a Beacon client as part of credentialing/re-credentialing activities delegated to Beacon
- *Providers/participating providers* with two or more documented *member complaints* in a six-month time frame relating to physical *accessibility*, physical appearance, adequacy of waiting/examining room space, or alleged quality of care issues

Site visits are arranged in advance. Following the site visit, Beacon will provide a written report detailing the findings, which report may include required monitoring where applicable and/or requirements for the *participating provider* to submit an action plan.

5.05 Updates

Providers/participating providers are required to report material changes to information included in credentialing and/or re-credentialing applications submitted to Beacon. Except as noted below, all such changes must be reported in writing within the time period provided for in the provider agreement, but not to exceed 10 calendar days of the *provider/participating provider* becoming aware of the information. Failure to comply may result in immediate termination of network participation status. The following is a list (not exhaustive) of examples of the types of material changes for which the above report is required:

- Any action against licenses, certifications, registrations, and/or *accreditation* status*

- Any legal or government action initiated that could materially affect the rendering of services to *members*
- Any legal action commenced by or on behalf of a *member*
- Any initiation of bankruptcy or insolvency proceedings, whether voluntary or involuntary
- Any other occurrence that could materially affect the rendering of services to *members*
- Discovery that a claim, suit or criminal or administrative proceeding is being brought against the *provider/participating provider* relating to the provider's delivery of care (i.e., a malpractice suit), compliance with community standards and/or to applicable laws, including but not limited to any action by licensing or *accreditation* entities and/or exclusions from a government-sponsored health benefit program (e.g., Medicare/Medicaid)

* The suspension, revocation, expiration and/or voluntary surrender of professional license/certification, DEA certificate, CDS certificate, and/or board certification must be reported within five calendar days of the effective date of the action. (Contact Beacon to coordinate the transition of members to the care of other participating providers where licensure/certification no longer meets Beacon's credentialing/re-credentialing standards and/or requirements pursuant to state and/or federal laws regarding the provision of services.)

Note: If a participating provider moves to or expands their practice and/or operations into another state, a copy of the participating provider's license/certification and malpractice/professional liability coverage is required in order to complete primary source verification and credential the participating provider to treat Beacon's members in another state.

Expiration, non-renewal and/or decrease in required malpractice or professional liability coverage must be reported 30 days prior to such change in coverage.

Any changes in demographic or contact information or changes in practice patterns, such as change of services and/or billing address, name change, coverage arrangements, tax identification number, hours of operation, and/or changes in ownership, must be provided to Beacon in advance of such changes. Beacon must receive 60 days' advance notice of any new programs or services offered by a facility provider in order to allow for completion of the credentialing process prior to provision of services to *members*.

Changes in ownership and/or management of *participating providers* may require negotiation and execution of consent to assignment and assumption agreements as related to *provider agreements* and the parties to provider agreements.

5.06 Delegation

Should Beacon, in its sole discretion, elect to delegate any credentialing and/or re-credentialing activities to a *participating provider*, such delegation is subject to all applicable *policies and procedures*, state and federal laws, rules and/or regulations, *accreditation* standards to which Beacon is or may be subject, and any client and/or government program specific requirements. Reference to possible delegation herein in no way obligates or requires Beacon to consider delegation of any credentialing and/or re-credentialing activities.

6. SANCTIONS

While efforts are made to resolve *provider/participating provider* credentialing/re-credentialing issues and/or quality issues through consultation and education, occasionally further action is necessary to

provide for quality service delivery and protection of *members*. Sanctions may be imposed for issues related to *member complaints/grievances*, credentialing/re-credentialing issues, professional competency and/or conduct issues, quality of care concerns/issues, and/or violations of state and/or federal laws, rules and/or regulations. Beacon's processes comply with all applicable local, state and/or federal reporting requirements regarding professional competence and/or conduct. The provider agrees to screen any employee, temporary employee, volunteer, consultants, governing body member, vendors prior to hire or contract, and monthly thereafter against U.S. Department of Health and Human Services Office of Inspector General's List of Excluded Individuals/Entities & Most Wanted Fugitives, the System for Award Management, and any other list of individuals excluded from participation in any Federal or State health care program and disclose to Beacon all exclusions and events that would make them ineligible to perform work related, directly or indirectly, to federal health care programs. Subject to modification based on the facts and circumstances in a given case, the following is a list of possible sanctions that may be imposed on *participating providers* by the NCC, any Beacon local credentialing committee, and/or the Beacon Provider Appeals Committee (PAC). The descriptions below are not in any specific order and should not be interpreted to mean that there is a series of sanctions; any one or more possible sanctions described below may be imposed in any order or sequence.

TYPE	DEFINITION
Consultation	A call is placed to notify the <i>participating provider</i> of the alleged action or incident. The <i>participating provider</i> will be provided with an explanation of possible sanctions if corrective actions are not taken. The call will be documented to include the date and subject for consultation. A copy of the consultation will be placed in the <i>participating provider's</i> file. Appropriate educational materials will be sent via certified mail.
Written Warning	A written notice is sent to the <i>participating provider</i> notifying him/her of the alleged action or incident. Possible sanctions, if corrective actions are not taken, will be explained. A copy of the letter is retained in the <i>participating provider's</i> file; educational material is sent via certified mail. Corrective action will be monitored as necessary.
Second Warning/ Monitoring	<p>At the discretion of the Medical Director, a second written notice may be sent to the <i>participating provider</i> and a copy of such letter shall remain in the <i>participating provider's</i> file. Additionally, the <i>participating provider</i> may be placed on monitoring when data indicates nonconformance with standards; and, if Beacon determines it is in the <i>members'</i> best interest, Beacon may elect to suspend new <i>member</i> referrals, new <i>member authorizations</i> and/or redirect all current <i>members</i> to other <i>participating providers</i>. The <i>participating provider</i> will be given written notice (and where applicable notice of <i>fair hearing</i> rights) via certified mail of the issues for which the <i>participating provider</i> is being monitored. A copy of the letter is placed in the <i>participating provider's</i> file.</p> <p>Facility/Program Participating Providers: An action plan will be provided consisting of steps that, when taken, will remedy the deficiencies or concerns that created the need for monitoring. The <i>participating provider</i> is expected to use best efforts to comply with the monitoring action plan. If an action plan has been sent, the <i>participating provider</i> is</p>

TYPE	DEFINITION
	<p>expected to notify Beacon in writing of the status of the issue for which monitoring was initiated at the end of the action plan timeline, or sooner if applicable. The <i>participating provider</i> is expected to keep Beacon updated in writing of all changes in the issue/concern that triggered monitoring.</p>
<p>Suspension</p>	<p>The <i>participating provider</i> may be suspended from network participation pending resolution of issues raised. Suspension requires <i>NCC</i> action. During suspension, Beacon may elect to suspend new <i>member</i> referrals, new <i>member authorizations</i> and/or redirect all current <i>members</i> to other <i>participating providers</i>. The <i>participating provider</i> will be notified by written notice via facsimile and certified mail of the issues for which the suspension occurred. A copy of the letter is placed in the <i>participating provider's</i> file. The suspension may last for a period of 30 calendar days during which time an investigation may take place. The <i>NCC</i> may extend this time period as necessary to gather additional information.</p> <p>Individual Participating Providers: The suspension may last for a period of up to 30 calendar days during which time an investigation may take place. The <i>NCC</i> may extend this time period as necessary to gather additional information.</p>
<p>Termination</p>	<p>The <i>participating provider</i> may be terminated from the network. Termination requires <i>NCC</i> action. The <i>participating provider</i> will be given written notice via facsimile and certified mail that the <i>participating provider</i> is being terminated from the network and the reason for the termination. A copy of the letter is put in the <i>participating provider's</i> file. <i>Members</i> in care will be notified and given assistance for referral to a new <i>participating provider</i> for continuing care, as necessary.</p>

7. APPEALS OF NATIONAL CREDENTIALING COMMITTEE/PROVIDER APPEALS COMMITTEE DECISIONS

The *NCC* and Beacon's local credentialing committees will give *providers/participating providers* written notice of the committee's decision regarding credentialing or re-credentialing applications submitted, any sanctions imposed or recommended, the reason for the decision, and of the *provider's/participating provider's* right to *appeal* adverse decisions along with an explanation of the applicable *appeals* procedure(s). Unless otherwise identified in such written notice, *providers/participating providers* have 30 calendar days from the date of the committee's notice of an adverse decision to file a written request for an *appeal*.

Provider/participating provider appeals of adverse credentialing/re-credentialing decisions of a Beacon local credentialing committee may be appealed to the *NCC*.

The *NCC*:

- Functions as a *peer review* body under *NCQA* standards
- Is made up of representatives from major clinical disciplines and includes *participating providers*

- Makes the final decision regarding:
 - Beacon credentialing/re-credentialing *policies and procedures*
 - Approval/denial/pending status for credentialing/re-credentialing applications
 - Determinations regarding possible *participating provider* sanctions identified above

Provider/participating provider appeals of adverse credentialing/re-credentialing decisions of the NCC may be appealed to the Beacon Provider Appeals Committee (PAC). The PAC is comprised of representatives of major clinical disciplines, *participating providers*, and clinical representatives from corporate departments within Beacon, none of whom have participated in the original NCC adverse decision under review.

Requests for *appeals* of adverse credentialing/re-credentialing decisions of the NCC should include an explanation of the reasons the *provider/participating provider* believes the NCC reached a decision to be in error and include supporting documentation. The PAC will review the explanation provided, the information previously reviewed by the NCC, and any additional information determined to be relevant. The PAC may request additional information from the *provider/participating provider* in order to make a determination or decision. The PAC will support, modify, or overturn the decision of the NCC. Written notification of the PAC's decision, an explanation of the decision, and any *appeal* and/or *fair hearing* rights available for adverse decisions, will be sent to the *provider/participating provider* within 14 business days after the PAC's record is complete.

7.01 Professional Review Activities/Fair Hearing Process

Individual *providers/participating providers*, where required by applicable law, may request a second level of *appeal/a fair hearing* when the PAC denies credentialing or re-credentialing, issues a sanction, or recommends termination of participation status of the *provider* from the Beacon provider network, where such denial, sanction, or recommendation is based on quality of care issues and/or issues related to professional competence or professional conduct.

Included in written notification of a PAC adverse decision based on quality of care issues and/or issues related to professional competency or professional conduct, will be an explanation of the decision, whether or not *fair hearing* rights are available to the *provider/participating provider*, and an explanation of *fair hearing* procedures if applicable.

Requests for a *fair hearing* must be submitted to Beacon within 30 calendar days of the date of the PAC notification of adverse decision to the *provider/participating provider*. While Beacon will make reasonable efforts to coordinate the date and time of *fair hearings* requested with the involved *provider/participating provider*, should Beacon and the involved *provider/participating provider* be unable to come to agreement on the date and time of the requested *fair hearing* Beacon will identify the date, time and location for the *fair hearing*, which date shall be within the 90 calendar day period following request for the *fair hearing* or within the timeframe required by applicable State regulations.

Beacon will identify *peer reviewers* who will participate as the *fair hearing* panel. Every effort will be made to include a representative of the discipline of the *provider/participating provider* requesting the *fair hearing* on the panel. Members of the *fair hearing* panel will not have participated in the prior adverse decisions of the PAC or NCC, and will be asked to represent that they do not have an economic interest adverse to the *provider/participating provider*. One *member* of the *fair hearing* panel will be selected to act as the hearing officer and will preside over the *fair hearing*.

Beacon and the *provider/participating provider* each have the right to legal representation if the *provider/participating provider* is eligible for a *fair hearing*. The *provider/participating provider* will receive

the written recommendation from the panel within 15 business days after the *fair hearing*. The *fair hearing* process as set forth above is subject to applicable state and/or federal laws and/or regulations.

8. OFFICE PROCEDURES

8.01 Member Rights and Responsibilities

The following is the list of Beacon's Member Rights & Responsibilities.

Beacon members have the right to:

- Be treated with respect and dignity.
- Have your personal information be private based on our policies and U.S. law.
- Get information that is easy to understand and in a language you know.
- Know about the way your health benefits work.
- Know about our company, services, and provider network.
- Know about your rights and responsibilities.
- Tell us what you think your rights and responsibilities should be.
- Get care when you need it.
- Talk with your provider about your treatment options - regardless of cost or benefit coverage.
- Decide with your provider what is the best plan for your care.
- Refuse treatment if you want, as allowed by the law.
- Get care without fear of any unnecessary restraint or seclusion.
- Decide who will make medical decisions for you if you cannot make them.
- Have someone speak for you when you talk with Beacon.
- See or change your medical record, as allowed by our policy and the law.
- Understand your bill.
- Expect reasonable adjustments for disabilities as allowed by law.
- Request a second opinion.
- Tell us your complaints.
- Appeal if you disagree with a decision made by Beacon about your care.
- Be treated fairly - even if you tell us your thoughts or appeal.

Beacon members have the role to:

- Give us and your providers the information needed to help you get the best possible care.
- Follow the health care plan that you agreed on with your health care provider.
- Talk to your provider before changing your treatment plan.
- Understand your health problems as well as you can. Work with your health care providers to make a treatment plan that you all agree on.
- Read all information about your health benefits and ask for help if you have questions.
- Follow all health plan rules and policies.
- Choose an In-Network primary care physician, also called a PCP, if your health plan requires it.
- Tell your health plan or Beacon of any changes to your name, address or insurance.
- Contact your provider when needed, or call 911 if you have any emergency.

Beacon's *Member Rights and Responsibilities Statement* is available as a one -page pdf in English and Spanish for download from the *website*. Providers and practitioners are encouraged to ensure your practice supports the Rights and Responsibilities of our Members.

8.02 Confidentiality, Privacy, and Security of Identifiable Health Information

Providers/participating providers are:

- Expected to comply with applicable federal and state privacy, confidentiality, and security laws, rules, and/or regulations, including without limitation the federal *Health Insurance Portability and Accountability Act* of 1996 (*HIPAA*), 42 C.F.R. Part 2, Health Information Technology for Economic and Clinical Health Act (*HITECH Act*), and the rules and regulations promulgated thereunder.
- Responsible for meeting their obligations under these laws, rules, and regulations, by implementing such activities as monitoring changes in the laws, implementing appropriate mitigation and corrective actions, and timely distribution of notices to patients (*members*), government agencies and the media when applicable.

Providers are also responsible for obtaining from members written release of authorizations to share Substance Use Disorder PHI for treatment, payment, or healthcare operations purposes with Beacon. The release should be retained on file.

With the enactment of the federal HIPAA and HITECH Act, members or their legal guardian give consent for the release of information regarding treatment, payment, and health care operations at the sign up for health insurance. Treatment, payment, and health care operations involve many different activities, including but not limited to:

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

In the event that Beacon receives a *complaint* or becomes aware of a potential violation or breach of an obligation to secure or protect *member* information, Beacon will notify the *provider/participating provider* utilizing the general *complaint* process, and request that the *provider/participating provider* respond to the allegation and implement corrective action when appropriate. *Participating providers* must respond to such requests and implement corrective action as indicated in communications from Beacon.

Providers/participating providers and their business associates interacting with Beacon staff should make every effort to keep *protected health information* (PHI) and personally identifiable information (PII) secure. If *provider/participating provider* does not use email encryption, Beacon recommends sending *protected health information* to Beacon through an inquiry in *ProviderConnect* or by secure fax.

8.03 Appointment and Availability Standards

Participating providers are expected to maintain established office/service hours and access to appointments with standards established by Beacon and/or as may be required by a given client of Beacon and/or specific government sponsored health benefit program. Beacon's provider contract requires that the hours of operation of all of our network providers are convenient to the population served and do not discriminate against members (e.g., hours of operation may be no less than those for

commercially-insured or public fee-for-service-insured individuals), and that services are available twenty-four hours a day, seven days a week, when medically necessary.

Except as otherwise required by a specific client and/or government sponsored health benefit program for *providers* participating in networks available to their respective *members* and/or as delineated in the *provider agreement*, the following are standards of *availability* for appointments which *participating providers* are required to maintain:

Emergency:	In an <i>emergency</i> situation, the <i>member</i> should be seen in person immediately or referred to appropriate <i>emergency service providers</i> . <i>Participating providers</i> who do not maintain 24-hour coverage must maintain a system for referring <i>members</i> to a source of <i>emergency</i> assistance during non-business hours. The preferred methods are through a live answering service or an on-call pager system. However, <i>participating providers</i> may elect to maintain a reliable recorded answering machine system through which <i>members</i> experiencing an <i>emergency</i> are given clear instructions about how to access immediate assistance after hours.
Emergent:	In an <i>emergent</i> situation, the <i>member</i> should be seen within six (6) hours of the request for an appointment or referred to appropriate <i>emergency service providers</i> .
Urgent:	In an <i>urgent</i> situation, the <i>member</i> must be offered the opportunity to be seen within 48 hours of a request for an appointment.
Routine:	In a <i>routine</i> situation, a <i>member</i> must be offered the opportunity to be seen within 14 calendar days or 10 business days of a request for an appointment.
Routine Follow-Up Office-Visit (non-prescriber)	In a routine follow-up situation, a member should be seen within 30 business days of initial visit.
Routine Follow-Up Office-Visit (prescriber)	In a routine follow-up situation, a member should be seen within 90 business days of initial visit.

8.04 Out-of-Office Coverage

Participating providers should:

- Contact their regional provider relations team via email located under ‘Contact Information’ on the ‘Beacon Health Options Providers’ section of the *website* or the Beacon National Provider Services Line at 800-397-1630 during normal business hours Mon. through Fri., 8 a.m. to 8 p.m. ET to inform Beacon of any unavailability or absence
- Submit the Beacon Leave of Absence/Out-of-Office Notification Form, located on the ‘Beacon Health Options Providers’ section of the *website*, to Beacon National Network Operations at the address below and advise of coverage arrangements in advance of vacation, sabbatical, illness, maternity leave (where applicable), and/or any other situation when *participating provider* is

unable to continue to treat Beacon *members* in active treatment. Such advance written notice should include: *participating provider's* name, licensure, practice locations affected, the reason for unavailability or absence and date range of unavailability or absence. Upon receipt of such advance notice, the *participating provider's* status in Beacon's systems is changed to 'inactive.'

Mail to: Beacon Health Options, Inc. OR Fax to: 866-612-7795
P.O. Box 989
Latham, NY 12110

Upon return, *participating providers* should contact the Beacon National Provider Services Line at 800-397-1630, Mon. through Fri., 8 a.m. to 8 p.m. ET and should notify Beacon's National Network Operations at the address above in writing. Failure to contact Beacon within 30 days of return may result in referral, *utilization management*, and claims processing delays due to the 'inactive' status placed in Beacon's systems. Failure to respond to communications from Beacon related to 'inactive' or out-of-office versus 'active' status in Beacon's systems within the time period provided for in such communications may result in termination of participation in Beacon's provider networks.

8.05 Termination and Leave of Absence

If a *participating provider* remains on inactive status for longer than six months, a reminder is sent informing the provider of the expiration date and the disenrollment process for failure to respond to said notice.

8.06 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 the plan and Beacon 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 that identifies the nature of the event, and the length of interruption of network status, claims submission or other administrative impact.

8.07 Requests for Additional Information

To maintain in-network status, *participating providers* must furnish Beacon with any requested documentation or information promptly. Failure to do so may result in the *participating provider's* status being changed from active to inactive. Inactive providers are ineligible to receive referrals or reimbursement as *participating providers* for services rendered to *members* of Beacon's clients and/or *payors*.

9. SERVICES TO MEMBERS

Pursuant to the terms of the *provider agreement*, *participating providers* are contracted and credentialed to provide identified *covered services* to *members*. *Covered services* should be rendered in:

- The same manner as services rendered to other patients
- Accordance with accepted medical standards and all applicable state and/or federal laws, rules, and/or regulations
- A quality and cost-effective manner

Participating providers should note that coverage for behavioral health services and any limitations and/or exclusions as well any *pre-authorization* and/or *certification* requirements for non-emergency services vary by benefit plan.

Participating providers must:

- Verify *member* eligibility and benefits using Beacon's provider portal prior to rendering non-emergency services as possession of a member identification card does not guarantee that the member is eligible for benefits.

Note: Member eligibility information on Beacon's provider portal 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 disenrollment's reported at a later date. Beacon recommends that providers check eligibility frequently.

- Document other or third party health benefit coverage for *members* (claims must be submitted to the primary initially)
- *Preauthorize* or *certify* care where required in Beacon's *policies and procedures* or the applicable *member* benefit plan, prior to rendering non-emergency services using Beacon's provider portal
- Collect *member expenses* from the *member* prior to, at the time of, or subsequent to services being rendered
- Provide continuous care for *members* or arrange for on-call coverage by other Beacon *participating providers* and communicate with members accordingly
- Adhere to the *accessibility* and *availability* standards established by Beacon
- Provide equal treatment to patients in a non-discriminatory manner, regardless of source of payment or coverage type or product
- Update demographic, office, and/or *participating provider* profile information promptly and in advance of changes using ProviderConnect
- Notify Beacon of potential inpatient discharge problems
- Advise *members* in writing of financial responsibility regarding services that are not covered, prior to rendering such service
- Cooperate with Beacon in coordinating continued care through alternative agencies, other vendors, or community resources when benefits end
- Notify Beacon of *members* who may be candidates for potential Care Management
- Coordinate care with a *member's* other health/medical care provider(s), either behavioral and/or medical providers who are treating the same or related (co-morbid) conditions
- Screen, evaluate, and treat (as medically appropriate), any behavioral health problem.
- Refer *members* to other *participating providers* when alternative or different mental health or substance use services are required
- Submit claims on behalf of *members*
- Upon written request by Beacon or third party *payors*, submit copies of *member* treatment records without charge (unless otherwise expressly provided for in the *provider agreement*)

- Make resources available to *members* who require culturally, linguistically, and/or disability competent care, such as, but not limited to, disability and language lines

9.01 Emergency Services

In the event of an *emergency* admission, *participating providers* should notify Beacon of the date of admission as soon as reasonably practical and in any event within 48 hours or within such alternative period of time specified in the *provider agreement* and/or state regulations. *Retrospective review* of such admissions and associated services is subject to the terms of the *member's* benefit plan.

Emergency services that are necessary to screen and stabilize a *member* are authorized without prior approval when:

- A prudent layperson, acting reasonably, believes that an emergency behavioral health condition exists
- An authorized representative, acting on behalf of Beacon, has authorized the provision of emergency services
- As otherwise required under applicable law

Beacon shall at all times authorize an emergency psychiatric evaluation as per the *member's* benefit plan.

9.02 Referrals

Participating providers may receive referrals from several sources, including but not limited to:

- *Providers* and/or other *participating providers*
- Self-referral of *members*;
- From Beacon
- Through an *EAP*

Participating providers needing to refer a *member* for other or additional services should contact Beacon to identify what are *covered services* under the *member's* benefit plan and any limitations, exclusions and/or notice, *pre-authorization*, or *certification* or *notification* requirements under their benefit plan. When possible, Beacon will seek to refer *members* to *participating providers* in the Beacon network.

9.03 EAP Transition to Health Plan Benefits

For those *members* participating in an *EAP* administered by Beacon and who may schedule and/or be referred for appointments for behavioral health services by network providers under their benefit plan, *participating providers* must be sure to obtain *pre-authorization* or *certification* as may be required under the *member's* benefit plan. Questions regarding what are *covered services* under the *member's* benefit plan and associated *member expenses* for *covered services* should be directed to Beacon by viewing a *member's* benefits on the 'Benefit' tab in ProviderConnect.

9.04 Coordination with Primary Care/Treating Providers

As part of care coordination activities, *participating providers* should identify all *providers/participating providers* involved in the medical and/or behavioral health care and treatment of a *member*. Subject to any required consent or *authorization* from the *member*, *participating providers* should coordinate the delivery of care to the *member* with these *providers/participating providers*. All coordination, including PCP coordination, should be documented accordingly in the member treatment record. Beacon consent forms are available through the *website*.

Tips to Improve Coordination of Care

1. Request a release of information from the member to coordinate with his/her medical providers. Use motivational interviewing techniques to encourage information sharing across providers.
 - a. Educate the member that care coordination improves patient safety and can lead to improved treatment outcomes. Explain in detail what will be shared and why.
 - b. Discuss any concerns about care coordination with the member. Encourage questions and provide adequate time for discussion.
2. Use a standard form to share information. You can use your own or one of the two versions available for free on Beacon's website: <https://www.beaconhealthoptions.com/providers/forms-and-resources/>.
 - a. Authorization for Behavioral Health Provider and Primary Care Provider to Share Confidential Information Form
 - b. Primary Care Provider Behavioral Health Communication Form
3. Follow a standard process for sharing and requesting information with the member's medical provider(s).
 - a. Call the PCP office and ask the office manager or receptionist how best to communicate and share information. Discuss a protocol for any urgent medical needs.
 - b. Routinely communicate with medical providers at specific points in treatment, such as when treatment begins, when there are changes in the member's status, or upon discharge.
4. Ensure that this coordination of care is documented in the member's medical record. Audit your own records for compliance with your policies and procedures.
5. Ensure that your intake paperwork/process includes medical history.
6. Keep the member in the communication loop, as clinically appropriate. Provide ongoing updates on communication between you and other providers.

9.05 Continuation following Provider Agreement Expiration or Termination

Non-renewal and termination of the *provider agreement* is the process by which the *provider agreement* is not renewed at the end of the identified period of time and accordingly ends by its own terms, or the *provider agreement* is terminated as provided for in the terms of the *provider agreement*.

All notices of non-renewal and/or termination of the *provider agreement* should be in writing and in accordance with the applicable terms of the *provider agreement*.

If a *participating provider* chooses to resign from the network and voluntarily surrender participation status, the *participating provider* must send Beacon written notice of such request and/or notice of termination of the *provider agreement* pursuant to the "without cause" termination provisions of the *provider agreement* (if any). Beacon will send the *participating provider* written acknowledgement of receipt of the *participating provider's* written request/notice and confirmation of the effective date of disenrollment/termination consistent with the provisions of the *provider agreement*. *Providers* who resign from network or voluntarily/involuntarily terminate the *provider agreement* are not eligible for re-application for six months following the effective date of disenrollment/termination. Exceptions to the six-month timeframe may be considered in certain situations.

The effective date of non-renewal or termination of the *provider agreement* is that date:

- Identified in the notice of non-renewal or termination of the *provider agreement* and consistent with the end of the specific notice period
- Mutually agreed upon in writing by the *participating provider* and Beacon

On or before the effective date of non-renewal or any termination of the *provider agreement*, *participating providers* must provide Beacon with a list of *members* for whom the *participating provider* has rendered services in the six-month period prior to the effective date of non-renewal or any termination of the *provider agreement*.

Participating providers must continue to provide *covered services* to *members* following the non-renewal or termination of the *provider agreement* pursuant to the terms of the *provider agreement* and for such time period(s) as are set out in the *provider agreement* or as required by government regulations. Payment for such *covered services* rendered to *members* following non-renewal or termination will be at the rates in the *provider agreement*.

9.06 Certain Regulatory Requirements

Provider agreements include provisions requiring *participating providers* to comply with all applicable state and/or federal laws, rules and/or regulations, including without limitation those related to the provision of mental health and/or substance use disorder services (e.g., required licensure/certification, workplace standards, non-discrimination, etc.); child or elder abuse; and duty-to-warn or obligation to report certain types of disclosures by patients; and those related to *fraud*, waste, and abuse. It is the responsibility of *providers* and *participating providers* to understand and comply with the professional and legal requirements within the state(s) in which *providers/participating providers* practice and/or render services.

By way of example, the Americans with Disabilities Act of 1990, as amended (ADA) contains provisions regarding services to certain individuals identified as covered under the ADA. *Participating providers* are encouraged to adapt services and their offices/locations to meet the special needs of *members*.

9.07 Fraud, Waste, and Abuse

Beacon interacts with employees, clients, vendors, *providers/participating providers*, and *members* using standard clinical and business ethics seeking to establish a culture that promotes the prevention, detection, and resolution of possible violations of laws and unethical conduct. In support of this, Beacon's compliance and anti-fraud plan was established to prevent and detect *fraud*, waste, or abuse in the behavioral health system through effective communication, training, review, and investigation. The plan, which includes Beacon's code of conduct, is intended to be a systematic process aimed at monitoring of operations, subcontractors, and *providers/participating providers'* compliance with applicable laws, regulations, and contractual obligations, as appropriate. *Participating providers* are required to comply with provisions of Beacon's code of conduct where applicable, including without limitation cooperation with claims investigations, payment reviews, benefit plan oversight and monitoring activities, government agency audits and reviews, and participation in training and education. Beacon's code of conduct is accessible on the *website*. If Beacon identifies that fraud, waste, or abuse has occurred based on information, data, or facts, Beacon must immediately notify relevant state and federal program integrity agencies following the completion of ordinary due diligence regarding a suspected fraud, waste, or abuse case.

Examples of provider fraud, waste, and abuse include altered medical records, patterns for billing that include billing for services not provided, up-coding, or bundling and unbundling, or medically unnecessary care. This list is not inclusive of all examples of potential provider fraud.

Examples of member fraud, waste, and abuse include under/unreported income, household membership (spouse/absent parent), out-of-state residence, third party liability, or narcotic use/sales/distribution. This list is not inclusive of all examples of potential member fraud.

10. PARTICIPATING PROVIDER COMPLAINTS, GRIEVANCES, AND APPEALS

The Beacon *complaint*, *grievance*, and *appeal* processes provide an effective method and dependable problem resolution procedure for the informal resolution of *participating provider complaints*, issues, concerns, or disputes that may arise related to the credentialing/re-credentialing process, *medical necessity* adverse determinations, administrative denials, claims processing, and payment or denial of claims, and otherwise related to the *provider agreement*.

Information about the process for *appeals* related to credentialing and/or re-credentialing decisions is set out in the *appeals* section of this *handbook*.

Information about the process for *appeals* of adverse determinations is set out in the *appeals* section of this *handbook*.

10.01 Complaints Regarding the Provider Agreement

Initial *participating provider complaints* regarding the terms of the *provider agreement* and/or performance by Beacon or the *participating provider* under the *provider agreement* should be submitted in writing to the local Beacon Engagement Center or to Beacon's Provider Relations Department at the address referenced in the Contacts section of this *handbook* within ten business days of the event that gave rise to the *complaint* or within ten business days from the time the *participating provider* should have reasonably first become aware of the event. Correspondence should include all documentation in support of the *complaint* and should provide, at a minimum:

- Reference to the specific term or provision in the *provider agreement* in dispute (It is helpful if the *participating provider* attaches a copy of the page or pages with the specific term or provision in dispute.)
- A detailed description of the nature of the *complaint* and what action or inaction allegedly is not consistent with or contrary to provision in the *provider agreement*
- The specific remedy requested for resolution.

Beacon will review the documentation, investigate the concern, and respond in writing to the *participating provider* within 30 business days of receipt of the *complaint* and requested documentation.

If the *participating provider* is not satisfied with the response from Beacon to the *participating provider's* initial *complaint* regarding the terms of the *provider agreement* and/or performance by Beacon or the *participating provider* under the *provider agreement*, the *participating provider* may file a second level *complaint* within 10 business days of receipt of Beacon's response to the *participating provider's* initial *complaint*, or in the absence of a response to the *participating provider's* initial *complaint*, within 35 business days of submission of the initial *complaint*, to the local Beacon Engagement Center or Beacon Provider Relations Department at the address referenced in the Contacts section of this *handbook*. The written second level *complaint* must contain, at a minimum, the same information required in the initial *complaint* as well as any additional information pertinent to the *complaint*. Beacon will review the documentation, investigate the concern, and provide a final written response to the *participating provider* within 30 business days of receipt of the second level *complaint* and requested documentation.

10.02 General Complaints and Grievances

Participating provider complaints regarding issues other than those related to the terms of the *provider agreement* and/or performance under the *provider agreement* (e.g., *service complaints*, *complaints* about

Beacon's *policies and procedures* or the *policies and procedures* applicable to a specific client benefit plan or government-sponsored health benefit program³) should be directed to the Beacon National Provider Services Line at 800-397-1630, Mon. through Fri., between 8 a.m. and 8 p.m. ET or in writing to:

Beacon Health Options, Inc.
Attn: Provider Complaint Department
P.O. Box 989
Latham, NY 12110

Beacon will acknowledge receipt of *participating provider complaints* verbally or in writing, and thereafter will investigate and attempt to reach a satisfactory resolution of the *complaint* within 30 calendar days of receipt of the *complaint*. A one-time extension of 15 calendar days can be taken by Beacon when a resolution cannot be reached within the above noted 30 calendar day timeframe and the extension is solely for the benefit of a *member*. Beacon will notify the *participating provider* verbally or in writing of the resolution to the *complaint*.

11. CLAIMS PROCEDURES AND E-COMMERCE INITIATIVE

11.01 E-Commerce Initiative

Beacon maintains claims processing procedures designed to comply with the requirements of client plans, government-sponsored health benefit programs, and applicable state and/or laws, rules, and/or regulations.

Providers in the Beacon network are strongly recommended to electronically submit all claims.

To electronically submit claims, Beacon's *participating providers* are strongly encouraged to use ProviderConnect, or one of the electronic claims resources detailed further in the section titled "Electronic Resources." These resources will expedite claims processing and assist *participating providers* to conduct certain claim submission and other routine transactions. Electronic claim submission is also accepted through clearinghouses. When using the services of a clearinghouse, providers must reference Beacon's Payer ID, **FHC & Affiliates**, to ensure Beacon receives those claims. The provider must also register for online services and submit the Intermediary Authorization Form to be linked with the clearinghouse.

Another option for providers for electronic claim submission is to install Beacon's EDI Claims Link for Windows Software on their computer(s). For information on these resources, please refer to the *website*.

11.02 Member Expenses

Member expenses due from the *member* for *covered services* are determined by the *member's* benefit plan. Detailed information about most of the amounts of *member expenses* due for inpatient, outpatient or *emergency covered services* can be obtained by viewing a *member's* benefits on the 'Benefit' tab in *ProviderConnect*. *Participating providers* are encouraged to contact Beacon's Customer Service at the member's toll-free number for questions regarding *member expenses*.

It is the responsibility of the *participating provider* to collect *member expenses* due to the *participating provider* for *covered services* rendered.

³ Questions about the *policies or procedures* applicable to a specific client benefit plan or government sponsored health benefit program should be directed to the Beacon Customer Service Department by calling the number on the *member's* identification card.

11.03 Preauthorization, Certification, or Notification

Preauthorization, certification, or notification requirements vary from plan to plan. *Participating providers* must determine if such requirements exist prior to the provision of non-emergency services to *members*. Information regarding Beacon's *policies and procedures* on *authorization, certification or notification* is located in the *utilization management/review* section of this *handbook*. *Participating providers* may not bill, charge or seek reimbursement or a deposit from *members* for services determined not to be *medically necessary*.

Providers/participating providers may verify *member* eligibility, submit and review *authorization/certification* requests, and view *authorizations/certifications* through ProviderConnect on the *website*.

11.04 No Balance Billing

Participating providers may not balance bill *members* for *covered services* rendered. This means that the *participating provider* may not bill, charge or seek reimbursement or a deposit, from the *member* for *covered services* except for applicable *member expenses*, and non-covered services. *Participating providers* are required to comply with provisions of Beacon's code of conduct where applicable, including, without limitation, cooperation with claims and billing procedures and participation in training and education. *Balance billing* education is provided by Beacon as included in quarterly *Fraud, Waste, and Abuse* provider training. It is the provider's responsibility to check benefits prior to beginning treatment of the member, to obtain appropriate authorization to provide services, if applicable, and to follow the procedures set forth in this Handbook.

11.05 Claim Submission Guidelines

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

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

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

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

Participating providers should submit claims consistent with national and industry standards. To ensure adherence to these standards, Beacon relies on claims edits and investigative analysis processes to identify claims that are not in accordance to national and industry standards and therefore were paid in

error. The claims edits and investigative analysis processes include CMS's National Correct Coding Initiative (NCCI), which consists of:

- Procedure-to-Procedure edits that define pairs of HCPCS/CPT codes that should not be reported together.
- Medically Unlikely Edits (MUE) or units-of-service edits. This component defines for each HCPCS/CPT code the number of units of service that is unlikely to be correct and therefore needs to be supported by medical records.
- Other Edits for Improperly Coded Claims – regulatory or level of care requirements for correct coding.

Examples of claims edits can include but are not limited to the following:

- Invalid procedure and/or diagnosis codes
- Invalid code for place of service
- Invalid or inappropriate modifier for a code
- State-specific edits to support Medicaid requirements
- Diagnosis codes that do not support the procedure
- Add-on codes reported without a primary procedure code
- Charges not supported by documentation based on review of medical records
- Claims from suspected fraudulent activities of providers and members that warrant additional review and consideration
- Services provided by a sanctioned provider or provider whose license has been revoked or restricted
- Incorrect fee schedule applied
- Duplicate claims paid in error
- No authorization on file for a service that requires prior authorization

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

Note: If a *participating provider* uses a clearinghouse to electronically submit claims, please provide the clearinghouse with Beacon's payer id, **FHC &Affiliates**. The provider must also submit the Intermediary Authorization Form to be linked with the clearinghouse.

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

Note: Client plan or government sponsored health benefit program specific claim submission requirements are located in the 'Beacon Health Options Providers' section of the *website* under 'Network-Specific.'

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

11.06 Required Claim Elements

Claims for *covered services* rendered to *members* should be submitted using *UB-04* or *CMS-1500* forms, or their respective electronic equivalent or successor forms, with all applicable fields completed and all elements/information required by Beacon included. Tip sheets containing Beacon's required claim fields to make a *clean claim* for the *UB04* and *CMS-1500* are located on the handbook page of the *website*.

**All data elements noted as required must be provided, but they must also be current and match what the subscriber's employer has on file. If the *member's* ID on the claim is illegible, or does not match what the subscriber's employer has provided, we may not be able to determine the claimant. We strongly recommend that you obtain a copy of the *member's* ID card, and validate that it is current at the time of each *visit*.

**There are times when supporting information is required to approve payment; if supporting documentation is not included, the claim may not be considered clean.

**Claims that are not submitted on a *CMS 1500 2012-02* or a *UB04* often will not contain the information we need to consider the claim clean and will cause the claim to reject or take a longer processing time. Claims submitted on old claim forms may be returned.

**Electronically submitted claims must also be in a *HIPAA 5010* compliant format and conform to the Beacon companion guide to be considered clean.

In addition, the claim should be free from defect or impropriety (including lack of required substantiating documentation) or circumstance requiring special treatment that prevents timely payment. If additional information is required, the *participating provider* will forward information reasonably requested for the purpose of consideration and in obtaining necessary information relating to *coordination of benefits*, subrogation, and verification of coverage, and health status.

Claims submission guidance, including required claim fields to make a *clean claim*, is available on the 'Beacon Health Options Providers' section of the *website*.

For paper claims, the use of scanning by means of Optical Character Recognition (OCR) technology allows for a more automated process of capturing information. The following elements are required to take advantage of this automated process. If the *participating provider* does not follow these guidelines, claims may be returned from the scanning vendor:

- Use machine print
- Use original red claim forms
- Use black ink
- Print claim data within the defined boxes on the claim form
- Use all capital letters
- Use a laser printer for best results
- Use correction tape for corrections

- Submit any notes on 8 ½" x 11" paper
- Use an eight-digit date format (e.g., 10212012)
- Use a fixed width font (Courier, for example)

11.07 Requests for Additional Information

To maintain in-network status and upon request by Beacon, or its authorized designee, *participating providers* must promptly furnish requested documentation or information related to and/or in support of claims submitted. Failure to do so may result in a change in network participation status from active to inactive. Inactive *providers* are ineligible to receive referrals or payment as a *participating provider* for *covered services* rendered to *members*.

11.08 Claims Processing

Beacon, or its designee, will process complete and accurate claims submitted by *providers/participating providers* for *covered services* rendered to *members* in accordance with normal claims processing *policies and procedures*, the payment terms included in the *provider agreement*, and applicable state and/or federal laws, rules and/or regulations with respect to timeliness of claims processing.

For Participating Providers Located in New York Only: Beacon, when performing claims processing activities as a delegate of a New York Public Health Law Article 44 licensed managed care organization and as such acting as a management contractor to such managed care organization(s), has initial responsibility for determining payment of claims for *covered services* rendered to *members* that are submitted by *participating providers* contracted with CHCS IPA, Inc. *Participating providers* contracted with CHCS IPA, Inc. understand and agree that CHCS IPA, Inc. may act as agent for such *participating providers* with regard to the processing of *claims* by Beacon and further that CHCS IPA, Inc. has the authority to play an active role in resolving claims processing issues that *participating providers* contracted with CHCS IPA, Inc. may have with Beacon (acting as a management contractor for the above noted New York managed care organizations).

Normal claims processing procedures may include, without limitation, the use of automated systems which compare claims submitted with *diagnosis codes* and/or procedure codes and associated billing or revenue codes. Automated systems may include edits that result in an adjustment of the payment to the *provider/participating provider* for *covered services* or in a request for submission of treatment records.

Participating provider agrees that no payment is due for *covered services* or claims submitted unless the *covered services* are clearly and accurately documented in the treatment record prior to submission of the claim.

Reimbursement for *covered services* provided in an inpatient facility, inpatient rehabilitation or residential setting/level of care will be at the contracted reimbursement rate in effect on the date of admission.

Payment for services rendered to *members* is impacted by the terms in the *provider agreement*, the *member's* eligibility at the time of the service, whether the services were *covered services*, if the services were *medically necessary*, compliance with any *preauthorization/certification/notification* requirements, *member expenses*, timely submission of the claim, claims processing procedures, overpayment recovery, and/or *coordination of benefits* activities.

Note: Regardless of any provision to the contrary, *participating providers* acknowledge and agree that the payment rates in the *provider agreement* extend and apply to *covered services* rendered to *members* of benefit plans administered in whole or in part by Beacon.

11.09 Provider Summary Vouchers

PSVs or remittance advices are the documents that identify the amount(s) paid and *member expenses* due from the *member*. *Providers/participating providers* should access PSVs through ProviderConnect or request copies of PSVs via facsimile through Beacon's automated PSV faxback service at 866-409-5958. Accessing PSVs electronically is a transaction subject to the e-commerce initiative. Additional information regarding access to PSVs is available at the 'Provider' section on the *website*.

11.10 Coordination of Benefits

Some *members* may have health benefits coverage from more than one source. In these instances, benefit coverage is coordinated between primary and secondary *payers*.

Participating providers should obtain information from *members* as to whether the *member* has health benefits coverage from more than one source, and if so provide this information to Beacon.

Coordination of benefits amongst different sources of coverage (*payers*) is governed by the terms of the *member's* benefit plan and applicable state and/or federal laws, rules and/or regulations. To the extent not otherwise required by applicable laws or regulations, *participating providers* agree that in no event will payment from primary and secondary *payers* for *covered services* rendered to *members* exceed the rate specified in the *provider agreement*.

Participating providers must submit a copy of the EOB through ProviderConnect that includes the primary payer's determination when submitting claims to Beacon. The services included in the claim submitted to Beacon should match the services included in the primary *payer* EOB.

Authorization, certification or notification requirements under the *member's* benefit plan still apply in *coordination of benefits* situations.

Note: Some benefit plans require that the *member* update at designated time periods (e.g., annually) other health benefit coverage information. Claims may be denied in the event the *member* fails to provide the required other coverage updates.

11.11 Overpayment Recovery

Participating providers should routinely review claims and payments in an effort to assure that they code correctly and have not received any overpayments. Beacon will notify *providers* and *participating providers* of overpayments identified by Beacon, clients and/or government agencies, and/or their respective designees. Overpayments include, but are not limited to:

- Claims paid in error
- Claims allowed/paid greater than billed
- Inpatient claim charges equal to the allowed amounts
- *Duplicate* payments
- Payments made for individuals whose benefit coverage is or was terminated
- Payments made for services in excess of applicable benefit limitations
- Payments made in excess of amounts due in instances of third party liability and/or *coordination of benefits*

- Claims submitted contrary to national and industry standards such as the CMS National Correct Coding Initiative (NCCI) and medically unlikely edits (MUE) described in the Claims Submission Guidelines

Subject to the terms of the *provider agreement* and applicable state and/or federal laws and/or regulations, Beacon or its designee will pursue recovery of overpayments through:

- Adjustment of the claim or claims in question creating a negative balance reflected on the *PSV* (claims remittance)
- Written notice of the overpayment and request for repayment of the claims identified as overpaid

Failure to respond to any written notice of and/or request for repayment of identified overpayments in the time period identified in the notice/request is deemed approval and agreement with the overpayment; thereafter, Beacon will adjust the claim or claims in question creating a negative balance. Any negative balance created will be offset against future claims payments until the negative balance is zeroed out and the full amount of the overpayment is recovered. Beacon may use automated processes for claims adjustments in the overpayment recovery process.

In those instances in which there is an outstanding negative balance as a result of claims adjustments for overpayments for more than 90 calendar days, Beacon reserves the right to issue a demand for re-payment. Should a *provider/participating provider* fail to respond and/or provide amounts demanded within the 30 calendar days of the date of the demand letter, Beacon will pursue all available legal and equitable remedies, including without limitation placing the outstanding overpayment amount (negative balance) into collections.

If the *provider/participating provider* disagrees with an overpayment recovery and/or request for re-payment of an overpayment, the *provider/participating provider* may request review to Beacon in writing such that the written request for review is received by Beacon on or before the date identified in the notice of overpayment recovery or request for re-payment of an overpayment. Please attach a copy of your written demand or request letter to your request for review and include the following information; *provider/participating provider's* name, identification number and contact information, *member* name, and number, a clear identification of the disputed items to include the date of service and the reason the disputed overpayments are being contested.

11.12 Requests for Review

Participating providers may request review of a Beacon claims determination. All requests for review must be submitted in writing or made telephonically to the address and/or telephone number on the *member's* identification card within 60 calendar days or the time period specified in the *provider agreement* (if any) from the date of Beacon's original claim determination.

Requests for review received beyond the above noted time period will not be reviewed and are considered 'expired.'

11.13 Claims Disputes

Participating providers must exhaust all administrative processes concerning unresolved claims disputes pursuant to the terms of the *provider agreement*, and more specifically any dispute resolution provisions, prior to pursuing any legal or equitable action.

11.14 Claims Billing Audits

Beacon reviews and monitors claims and billing practices of *providers/participating providers* in response to referrals. Referrals may be received from a variety of sources, including without limitation:

- *Members*
- External referrals from state, federal and other regulatory agencies
- Internal staff
- Data analysis
- Whistleblowers

Beacon also conducts unplanned audits. Beacon conducts the majority of its audits by reviewing records *providers/participating providers* either scan or mail to Beacon, but in some instances on-site audits are performed as well. Record review audits, or discovery audits, entail requesting an initial sample⁴ of records from the *provider/participating provider* to compare against claims submission records. Following the review of the initial sample, Beacon may request additional records and pursue a full/comprehensive audit. Records reviewed may include, but are not limited to, financial, administrative, current and past staff rosters, and treatment records. For the purposes of Beacon audits, the ‘treatment record’ includes, but is not limited to, progress notes, medication prescriptions and monitoring, documentation of counseling sessions, the modalities and frequency of treatment furnished, and results of clinical tests. It may also include summaries of the *diagnosis*, functional status, treatment plan, symptoms, prognosis, and progress to date.

Providers/participating providers must supply copies of requested documents to Beacon within the required timeframe. The required timeframe will vary based on the number of records requested but will not normally be less than 10 business days when *providers/participating providers* are asked to either scan or mail records to Beacon. For the purpose of on-site audits, *providers/participating providers* must make records available to Beacon’s staff during the *provider’s* audit. *Providers/participating providers* are required to sign a form certifying all requested records and documentation were submitted or made available for the audit. Beacon will not accept additional or missing documentation and/or records once this form is signed, including for the purposes of a request for appeal. Beacon will not reimburse *providers/participating providers* for copying fees related to providing of documents and/or treatment records requested in the course of a claims billing audit, unless otherwise specifically required by applicable state or federal law, rule, or regulation.

In the course of an audit, documents and records provided are compared against the claims submitted by the *provider/participating provider*. Claims must be supported by adequate documentation of the treatment and services rendered. *Participating providers’* strict adherence to these guidelines is required. A *member’s* treatment record must include the following core elements: *member* name, date of service, rendering *provider* signature and/or rendering *provider* name and credentials, *diagnosis code*, start and stop times (e.g., 9:00 to 9:50), time-based *CPT* codes, and service code to substantiate the billed services. Documentation must also meet the requirements outlined in the ‘Treatment Record Standards and Guidelines’ section of this handbook. Beacon coordinates claims billing audits with appropriate Beacon clinical representatives when necessary. The lack of proper documentation for services rendered could result in denial of payment, or, if payment has already been issued, a request for refund.

⁴ Unless otherwise required by a specific client or a government agency, Beacon utilizes the Office of Inspector General’s (OIG) RAT-STATS tool to select a sample of eligible records.

Following completion of review of the documents and records received, Beacon will provide a written report of the findings to the *provider/participating provider*. In some instances, such report of the findings may include a request for additional records.

Beacon has established an audit error rate threshold of 10 percent to determine whether the *provider/participating provider* had accurate, complete and timely claim/encounter submissions for the audit review period. Depending on the audit error rate and the corresponding audit results, Beacon's report of findings may include specific requirements for corrective action to be implemented by the *provider/participating provider* if the audit identifies improper or unsubstantiated billings. Requirements may include, but are not limited to:

- **Education/Training** – Beacon may require the *provider/participating provider* to work with provider relations to develop an educational/training program addressing the deficiencies identified. Beacon may provide tools to assist the *provider/participating provider* in correcting such deficiencies.
- **Corrective Action Plan** – Beacon may require the *provider/participating provider* to submit a corrective action plan identifying steps the *provider/participating provider* will take to correct all identified deficiencies. Corrective action plans should include, at a minimum, confirmation of the *provider's/participating provider's* understanding of the audit findings and agreement to correct the identified deficiencies within a specific timeframe.
- **Repayment of Claims** – The audit report will specify any overpayments to be paid to Beacon. The overpayment amount will be based on the deficiency determined in the audit process and/or the value of the claims identified as billed without accurate or supportive documentation. The *provider/participating provider* will be responsible for paying the amount owed, based on Beacon's findings within 10 business days, unless the *provider/participating provider* has an approved installment payment plan.
- **Monitoring** – Beacon may require monitoring of claims submissions and treatment records in 90-day increments until compliance is demonstrated. The *provider's/participating provider's* monitored claims are not submitted for payment until each is reviewed for accuracy and correctness.
- **Referral to NCC Reporting/Contract Termination** – Beacon's audit team may decide that the results of an audit warrant referral to the NCC. If a *provider/participating provider* reported to the NCC is not immediately dis-enrolled and is permitted to remain active by accepting a corrective action and/or recoupment plan, but later fails to follow through, the *provider/participating provider* may be re-addressed by the NCC and involuntarily dis-enrolled for breach of contract.

11.15 Appeal

If the *participating provider* disagrees with an audit report's findings, the *participating provider* may request an *appeal* of the audit report of findings. All *appeals* must be submitted in writing and received by Beacon on or before the due date identified in the report of findings letter. Beacon has no obligation to consider late-filed appeals.

Appeals must include:

- A copy of the audit report of findings letter
- The *participating provider's* name and identification number
- Contact information

- Identification of the claims at issue, including the name or names of the *members*, dates of service, and an explanation of the reason/basis for the dispute.

Absent extraordinary circumstances, Beacon will not accept or consider documentation and/or records that were not submitted with the original audit submission.

The *participating provider's appeal* will be presented to Beacon's National Compliance – Corporate SIU Subcommittee within 45 days of receiving the *participating provider's* request for *appeal*. The subcommittee is comprised of Beacon employees who have not been involved in reaching the prior findings. The subcommittee will review the *participating provider's appeal* documentation, discuss the facts of the case, as well as any applicable contractual, state or federal statutes. The Beacon staff *member/auditor* who completed the *participating provider's* audit will present his/her audit findings to the subcommittee but will not vote on the *appeal* itself. The subcommittee will uphold, overturn, uphold in-part, or pend the *appeal* for more information. Once a vote is taken, it will be documented and communicated to the *participating provider* within 10 business days of the subcommittee's meeting. If additional time is needed to complete the *appeal*, Beacon will submit a letter of extension to the *participating provider* requesting any additional information required of the *participating provider* and estimating a time of completion. If repayments or a corrective action plan (CAP) are required, the *participating provider* must submit the required repayments or CAP within 10 business days of receiving the subcommittee's findings letter, unless an installment payment plan is approved.

Beacon will take appropriate legal and administrative action in the event a *provider/participating provider* fails to supply requested documentation and *member* records or fails to cooperate with a Beacon investigation or corrective action plan. Beacon may also seek termination of the *provider agreement* and/or actions to recover amounts previously paid on claims involved in the investigation or requests for records. Beacon will report any suspicion or knowledge of *fraud*, waste, or abuse to the appropriate authorities or regulatory agency as required or when appropriate.

11.16 Reporting *Fraud, Waste, and Abuse*

Providers/participating providers should report *fraud*, waste, and abuse, or suspicious activity thereof, such as inappropriate billing practices (e.g., billing for services not rendered or use of *CPT* codes not documented in the treatment record). Reports and questions may be made in writing to Beacon at the address below or by calling the Beacon Ethics Hotline at 888-293-3027.

Beacon Health Options
Attn: Corporate SIU
SIU@beaconhealthoptions.com

12. UTILIZATION MANAGEMENT

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

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

The Beacon *utilization management* program includes processes to address:

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

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

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

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

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

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

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

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

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

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

12.01 New and Emerging Technologies

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

12.02 Treatment Planning

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

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

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

12.03 Clinical Review Process

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

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

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

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

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

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

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

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

12.04 Retrospective Review

When a *provider/participating provider* requests a *retrospective review* for services previously rendered, Beacon will first determine whether such a *retrospective review* is available under the *member's* benefit plan and request the reason for the *retrospective review* (e.g., *emergency* admission, no presentation of a Beacon *member* identification card, etc.). In cases where a *retrospective review* is available, services will be reviewed as provided for in this *handbook*. In cases where a *retrospective review* is not available under the *member's* benefit plan and/or and where the *provider/participating provider* fails to follow administrative process and requirements for *authorization*, *certification*, and/or *notification*, the request for *retrospective review* may be administratively denied. Subject to any client, government-sponsored health benefit program, and/or benefit plan specific requirements, the chart below references the standard timeframes applicable to the type of review request:

STANDARD DETERMINATION TIME FRAMES

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

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

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

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

12.05 Definition of Medical Necessity

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

- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (current *ICD* or *DSM*) that threatens life, causes pain or suffering, or results in illness or infirmity
- Expected to improve an individual's condition or level of functioning
- Individualized, specific and consistent with symptoms and *diagnosis*, and not in excess of patient's needs

- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications
- Reflective of a level of service that is safe, where no equally effective, more conservative and less costly treatment is available
- Not primarily intended for the convenience of the recipient, caretaker or *provider/participating provider*
- No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency
- Not a substitute for non-treatment services addressing environmental factors

12.06 Medical Necessity Criteria

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

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

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

Beacon has five (5) types of MNC, depending on client or state contractual requirements and lines of business:

- A. Centers for Medicare and Medicaid (CMS) Criteria – National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) contained in the Medicare Coverage Database (<https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>).
- B. Change Healthcare's InterQual Behavioral Health Criteria
- C. American Society of Addiction Medicine (ASAM) Criteria
- D. Custom criteria, including state or client specific levels of care
- E. Beacon's National Medical Necessity Criteria

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

Medical Necessity Criteria is available on Beacon's website via hyperlinks whenever possible and is available upon request. To order a copy of the ASAM criteria, please go to the following website:

www.asam.org/PatientPlacementCriteria.html. In addition, Beacon disseminates criteria sets via the website, provider handbook, provider forums, newsletters, and individual training sessions.

12.07 Clinical Practice Guidelines

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

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

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

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

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

12.08 Beacon's Care Management System

Members and *participating providers* may access the Beacon care management system through any of the following avenues:

- 24-hour toll-free *emergency care/clinical referral* line
- Direct registration/certification of care through *ProviderConnect* for participating providers
- Direct registration of care through the *Interactive Voice Response (IVR)* system (in those local Beacon Engagement Centers where *IVR* is used)
- Direct *authorization/certification* of all *levels of care* through referral by a Beacon *CCM*
- *Emergency services* through freestanding psychiatric hospitals, medical hospitals with psychiatric units, *emergency rooms*, or crisis response teams

If a call is received from a *member* requesting a referral and/or information about *participating providers* in the *member's* location, *CCMs* may conduct a brief screening to assess whether there is a need for *urgent* or *emergent* care. Referrals are made to *participating providers*, taking into account *member* preferences

such as geographic location, hours of service, cultural or language requirements, ethnicity, type of degree the *participating provider* holds and gender. Additionally, the *member* may require a clinician with a specialty such as treatment of eating disorders. In all cases, where available, the *CCM* will assist in arranging care for the *member*. The name, location, and phone number of at least three *participating providers* will be given to the *member*.

12.09 Clinical Care Manager Reviews

Beacon's *CCMs* base reviews on established criteria adopted by Beacon and/or criteria developed by Beacon. *CCMs* are trained to match the needs of *members* to appropriate services, *levels of care*, treatment and length of stay, and community supports. This requires careful consideration of the intensity and severity of clinical data presented, with the goal of quality treatment in the least restrictive environment. The clinical integrity of the *utilization management* program seeks to provide that *members* who present for care are appropriately monitored and that comprehensive reviews of all *levels of care* are provided. Those cases that appear to be outside of best practice guidelines or appear to have extraordinary treatment needs are referred for specialized reviews. These may include evaluation for intensive care management, clinical rounds, *peer advisor* review or more frequent *CCM* review.

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

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

- Demographics
- *Diagnosis* (current DSM or ICD)
- Reason for admission/precipitant
- Suicidal/homicidal risk, including:
 - Ideation
 - Plan
 - Intent
 - Psychotic/Non-Psychotic (e.g., command hallucinations, paranoid delusions)
- Substance use disorder history
 - Type
 - Amount
 - Withdrawal symptoms
 - Vital signs
 - Date(s) of initial use and last use
 - Date(s) of periods of sobriety
- Other presenting problem/symptomatology description, if applicable

- Progress since admission (if *concurrent review*)
- Medical problems
 - Medical history
 - Organic cause of psychiatric symptoms/behaviors
 - Medical problems which exacerbate psychiatric or substance use disorder symptoms/behaviors
- Current medications
 - Type(s)
 - Dosage(s)
 - Date(s)
 - Duration
 - Response
 - Provider(s)
- Primary care physician (PCP) interface, if applicable
- Other behavioral health care provider interface, if applicable
- General level of functioning
 - Sleep, appetite
 - Mental status
 - ADLs (Activities of Daily Living)
- Psychological stressors and supports
 - Socioeconomic
 - Family
 - Legal
 - Social
 - Abuse, neglect, domestic violence (as appropriate)
- Response to previous treatment
 - Previous treatment history, most recent treatment, past treatment failures
 - Relapse/recidivism, motivation for treatment
 - Indications of compliance with treatment recommendations
- Treatment plan
 - Estimated length of stay
 - Treatment goals
 - Specific planned interventions
 - Family involvement

- Precautions for specific risk behaviors
- Educational component for regulatory compliance and substance use disorder situations
- Discharge plan
 - Aftercare required upon discharge
 - Barriers to discharge

12.10 Inpatient or Higher Levels of Care

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

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

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

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

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

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

Continued stay reviews:

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

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

Effective January 1, 2017, Medicaid managed care plans (MMCPs) are to comply with New York State Insurance Law (INSL) Section 4303(k)(4), as provided by section three of Part B of Chapter 71 of 2016. This section prohibits prior the need for authorization for inpatient substance use disorder (SUD) treatment when provided in a participating OASAS-certified facility. In addition, it prohibits concurrent utilization review during the first 14 days of medically necessary inpatient SUD treatment when provided in a participating OASAS-certified facility, and where the MMCP was notified and received an initial treatment plan from the provider within 48 hours of admission. The OASAS facility is also required to provide periodic clinical updates to the MMCP during the stay.

The statute does not guarantee a member 14 days of treatment. After the initial 14 days, utilization review may be performed for any part of the stay; however, medical necessity denials issued under these circumstances may only be made in accordance with LOCADTR and the Medicaid Managed Care Model Contract.

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

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

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

12.11 Discharge Planning

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

- Discharge date
- Aftercare date
 - Date of first post-discharge appointment (must occur within seven days of discharge)
 - With whom (name, credentials)
 - Where (*level of care*, program/facility name)

- Other treatment resources to be utilized:
 - Types
 - Frequency
- Medications
 - Patient/family education regarding purpose and possible side effects
 - Medication plan including responsible parties
- Support systems
 - Familial, occupational and social support systems available to the patient. If key supports are absent or problematic, how has this been addressed
 - Community resources/self-help groups recommended (note purpose)
- *EAP* linkage
 - If indicated (e.g., for substance use aftercare, workplace issues, such as Return-to-Work Conference, enhanced wraparound services) indicate how this will occur
- Medical aftercare (if indicated, note plan, including responsible parties)
- Family/work community preparation
 - Family illness education, work or school coordination, (e.g., *EAP* and Return-to-Work Conference) or other preparation done to support successful community reintegration. Note specific plan, including responsible parties and their understanding of the plan.

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

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

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

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

When requested, please:

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

12.13 Adverse Clinical Determination/Peer Review

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

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

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

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

All written or electronic adverse determination notices include:

- a. The specific reason(s) for the determination not to certify
- b. A statement that the clinical rationale, criteria, (or copy of the relevant medical necessity criteria), guidelines, or protocols used to make the decision will be provided, in writing, upon request
- c. The right of the *provider/participating provider* to request a reconsideration within three business days of receipt of the notice when a *medical necessity* denial is issued without a peer-to-peer conversation having taken place, or when an administrative denial is issued because of the failure of a *provider/participating provider* to respond to a request for peer-to-peer conversation within a specified timeframe
- d. Rights to and instructions for initiating an *appeal*, including the opportunity to request an *expedited appeal* if applicable for first level *appeals*, and information about the *appeal* process
- e. The right to request an *appeal* verbally, in writing, or via fax transmission
- f. The timeframe for requesting an *appeal*
- g. The opportunity for the *member*, *provider/participating provider* to submit, for consideration as part of the *appeals* process, written comments, documents, records, and other information relating to the case

- h. Information regarding the appeals process for urgent care including that expedited external review may occur concurrently
- i. The *member's* right to bring a civil action under the Employer Retirement Income Security Act of 1974 (ERISA), when applicable

12.14 Telehealth

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

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

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

12.15 Outpatient Services

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

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

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

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

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

12.16 Appeal of Adverse Determinations

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

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

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

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

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

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

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

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

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

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

Standard Turnaround Times for *Appeal* Completion and Notice by Type of Care Request⁵

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

⁵ LACK OF INFORMATION – No extensions are allowed for lack of information or for “reasons beyond the control of Beacon”. If information submitted is incomplete, Beacon has the option of requesting the necessary information; however, the decision must still be made within the timeframe for making the *appeal* decision, or making the decision based on information on hand.

12.17 Clinical Appeals

Clinical appeal reviews of adverse *medical necessity* determinations administered by Beacon are conducted by an *Appeal Reviewer* in the same profession and/or in a similar specialty as typically manages the behavioral health condition, procedure or treatment, as deemed appropriate, or a committee of practitioners having similar qualifications of an *appeal reviewer*. *Clinical appeal* reviewers are neither the individual who made the original adverse *medical necessity* determination, nor the subordinate of such an individual.

Written notice of Level I and Level II *clinical appeal* determinations upholding the original adverse determination (or Level I *appeal* where applicable), in whole or in part, will include:

- The principal reason or reasons for the determination
- Reference to the medical necessity criteria and/or guidelines used to be made available upon request
- The procedures for initiating the next step in the appeal process, if any
- The right of the member and/or the provider/participating provider to submit additional information in support of the next level of appeal, if any
- Where applicable information related to the member's right to file suit and/or to pursue other voluntary dispute options as required by ERISA, or provisions as may be required by applicable laws, regulations or government-sponsored health benefits programs (e.g., Medicare Advantage or Managed Medicaid)

TYPE OF APPEAL	PROCESS
<p>Level I (Initial)</p>	<p>Standard Appeals</p> <p>Upon being assigned a case for review of an adverse determination <i>clinical appeal</i>, an <i>Appeal Reviewer</i> will investigate the substance of the <i>appeal</i>, including aspects of the clinical care involved, and review of documents, records, or other information submitted with the request for the Level I <i>appeal</i>, regardless of whether such information was also submitted or considered in the original adverse determination and the applicable medical necessity criteria. The <i>Appeal Reviewer</i> will attempt to contact the <i>provider/participating provider</i> (or the clinical representative of facility or program <i>providers/participating providers</i>) directly to conduct a telephonic review as appropriate. Based on consideration of all pertinent information, including relevant medical necessity criteria and guidelines, the <i>Appeal Reviewer</i> will make a determination to reverse (i.e., overturn) the original adverse determination in whole or part, or to uphold the original adverse determination.</p> <p>When an adverse determination <i>clinical appeal</i> review is conducted and completed telephonically, the <i>Appeal Reviewer</i> will verbally inform the <i>provider/participating provider</i> of the determination. If the determination is to reverse the original adverse determination, the <i>Appeal Reviewer</i> will identify the length of stay, <i>level of care</i> and/or number of service units or sessions determined to be <i>medically necessary</i>. If the determination is to uphold the adverse determination, the <i>Appeal Reviewer</i> includes any recommendations</p>

TYPE OF APPEAL	PROCESS
	<p>for treatment for which <i>medical necessity</i> could be confirmed and the procedure for following the next step in the <i>appeals</i> process, if any.</p> <p>Expedited Appeals</p> <p>An <i>expedited appeal</i> is a request to review an adverse determination concerning admission, continued stay, or other behavioral health care services for a <i>member</i> who has received <i>urgent</i> services but has not been discharged from a facility, or when a delay in decision making might seriously jeopardize the life or health of the <i>member</i>. Only a Level I <i>appeal</i> can be processed as an <i>expedited appeal</i>. Beacon follows the same determination procedures outlined above for standard <i>appeals</i>, but issues the decision and notification for all <i>expedited appeals</i> within 72 hours of the <i>appeal</i> request. <i>Expedited appeals</i> are conducted by an <i>Appeal Reviewer</i> not involved in the original adverse determination. Determinations are communicated by telephone on the same day as the determination, with written notification sent within the 72-hour timeframe.</p> <p>Continued coverage is provided for concurrent (expedited) appeals for inpatient substance use disorder treatment that is provided by an in-network OASAS-certified facility while the appeal is pending.</p>
Level II	<p>Upon being assigned a case for review of an adverse determination <i>clinical appeal</i>, an <i>Appeal Reviewer</i> will investigate the substance of the <i>appeal</i>, including aspects of the clinical care involved, and review of documents, records, or other information submitted with the request for the Level II <i>appeal</i>, regardless of whether such information was also submitted or considered in the original adverse determination or the Level I <i>appeal</i> and the applicable medical necessity criteria. The <i>Appeal Reviewer</i> will attempt to contact the <i>provider/participating provider</i> (or the clinical representative of facility or program <i>providers/participating providers</i>) directly to conduct a telephonic review as appropriate. Based on consideration of all pertinent information, including relevant medical necessity criteria and guidelines, the <i>Appeal Reviewer</i> will make a determination to reverse (i.e., overturn) the Level I <i>appeal</i> determination in whole or part, or to uphold the original adverse determination and Level I <i>appeal</i> determination.</p> <p>This level of <i>clinical appeal</i> involves a review of all pertinent clinical information by another <i>Peer Reviewer</i> who has not been previously involved with the adverse determination, or a Level II Appeal Committee, depending on the <i>member's</i> benefit plan and what administrative activities have been delegated to Beacon by the client plan. When a Level II <i>clinical appeal</i> is conducted by a Level II Appeal Committee, in some circumstances and only where indicated in the notice of Level I <i>appeal</i> determination the <i>member</i> may have the right to appear before the Level II Appeal Committee.</p>
Retrospective	<p>A retrospective <i>clinical appeal</i> is one requested after the <i>member</i> has been discharged from the <i>level of care</i> or treatment service under consideration.</p>

TYPE OF APPEAL	PROCESS
	<p>Retrospective <i>clinical appeals</i> of adverse determinations require that the <i>provider/participating provider</i> send in specific sections of the treatment record for review. Retrospective <i>clinical appeal</i> determination notices are issued within the decision timeframe and contain the required information outlined above under ‘Standard Appeals.’</p> <p>Note: There is only one level of retrospective <i>appeal</i>.</p>

12.18 Administrative Appeals

Administrative appeal reviews of adverse determinations (not based on medical necessity) are conducted by the applicable Beacon Region or Engagement Center Vice President or their designee, or by a Beacon committee. *Administrative appeal* reviewers are neither the individual who made the original adverse determination, nor the subordinate of such an individual.

The types and levels of *appeal*, as well as decision and notification requirements mirror those described above for *clinical appeals*. However, if an administrative denial is in place, it must be resolved *before* the clinical request can be processed. The result of this process can include three scenarios:

1. The administrative denial is upheld and the clinical request is never processed
2. The administrative denial is overturned; however, a clinical review is not necessary (e.g., timely filing waiver approved, corrected claim submitted, etc.)
3. The administrative denial is overturned, the clinical requested is processed, and a clinical determination is made

12.19 Final Appeal Level

For those benefit plans that provide for a final stage of *appeal* (clinical or administrative) for the *member*, Beacon will cooperate with the requirements of such final stage of *appeal* and where agreed upon with the client plan coordinate such final stage of *appeal*. Final stages of *appeal* may include reviews by an arbitration board, benefits committee, external review entities, state agency sponsored external review processes, and government sponsored health benefits program medical directors, or other review entities and/or processes. Information about and procedures for such final *appeal* level, if any, will be included in notice of *appeal* determination for the last level of *appeal* available before final *appeals*.

13. QUALITY MANAGEMENT/QUALITY IMPROVEMENT

Beacon utilizes a *Continuous Quality Improvement (CQI)* philosophy through which Beacon directly or through its authorized designees, monitors and evaluates appropriateness of care and service, identifies opportunities for improving quality and access, establishes *quality improvement* initiatives, and monitors resolution of identified problem areas. This includes monitoring and evaluation of services performed by Beacon or its designees, as well as behavioral health services rendered by *providers* and *participating providers*.

Beacon’s comprehensive Quality Management Program (QMP) includes Quality Management (QM) *policies and procedures* applicable to all *participating providers*, strategies and major activities performed to provide for consistency and excellence in the delivery of services, includes a program description, an annual work plan that includes goals and objectives and specific QM related activities for the upcoming

year and evaluation of the effectiveness of those activities. *Participating providers* are responsible for adhering to the QMP and are encouraged to provide comments to Beacon regarding ongoing QMP activities through direct telephone communications and/or via the Provider *website*. Beacon requires each provider to also have its own internal QM and I Program to continually assess quality of care, access to care, and compliance with medical necessity criteria.

13.01 Quality Management Committees

The Beacon Executive Oversight Committee (EOC) has ultimate accountability for the oversight and effectiveness of the QMP. The Corporate Quality Committee (CQC) is the body responsible for coordinating all corporate level quality management activities and providing oversight, direction, and consultation to the Region or Engagement Center QM committees as well as specific quality management programs. Beacon Region or Engagement Center QM committees are responsible for oversight of the day-to-day operations of their specific QM programs that includes reporting and communication of their activities and findings to the CQC as well as incorporating activities in their Region or Engagement Center as part of oversight monitoring responsibilities.

Certain functional areas within Beacon (e.g., claims) maintain quality management programs specific to the activities and services performed. Quality programs within functional areas are responsible for coordinating their quality management programs with the overarching QMP by communicating their findings and activities to the CQC and incorporating activities into their respective QMP.

The CQC reviews and approves the Corporate QM Program Description, QM Program Evaluation, and integrated QM/UM Work plan at least annually and at the time of any revision. The CQC receives a quarterly summary of all QM activities included in the work plan.

13.02 Quality Management Program Overview

The Beacon Corporate Quality Management Program (QMP) monitors and evaluates quality across the entire range of services provided by the company. Along with the trending of quality issues at the Region or Service Center level, the corporate QMP is intended to ensure that structure and processes are in place to lead to desired outcomes for *members*, clients, *providers/participating practitioners*, and internal clients.

The scope of the Corporate QMP includes:

- a. Clinical services and *Utilization Management* Programs
- b. Supporting improvement of continuity and *coordination of care*
- c. Case Management/Intensive Case Management/Targeted Case Management
- d. *Quality Improvement* Activities (QIAs)/Projects (QIPs)
- e. Outcome Measurement and data analysis
- f. Network Management/Provider Relations Activities
- g. Member Experience Survey
- h. Clinical Treatment Record Evaluation
- i. *Service Availability* and Access to Care
- j. Practitioner and Provider Quality Performance
- k. Annually evaluating *member Complaints* and *Grievances (Appeals)* using valid methodology

- I. *Member* Rights and Responsibilities
- m. Patient Safety Activities (including identification of safety issues during prospective reviews)
- n. Clinical and *Administrative Denials and Appeals*
- o. Performance Indicator development and monitoring activities
- p. Health Literacy and Cultural Competency assurance
- q. Compliance with Section 1557, nondiscrimination law in the Affordable Care Act (ACA)
- r. Promotion of e-technologies to improve *member* access and understanding of health benefits
- s. Promotion of the use of member self-management tools
- t. Screening Programs
- u. Complaints and Grievances

Several of the above activities and processes are described in greater detail in other sections of this *handbook*.

13.03 Role of Participating Providers

Participating practitioners/providers are informed about the QMP via the Beacon Provider Handbook, *provider* newsletters, *website information*, direct mailings, email provider alerts, seminars and training programs. Many of these media venues provide network *practitioners/providers* with the opportunity to be involved and provide input into the QM and UM Programs. Additional opportunities to be involved include representation on the National Credentialing and Provider Appeals Sub-Committees as well as on various committees and sub-committees and/or workgroups at the Regional or Engagement Center level (e.g., Credentialing Committee and *Clinical Advisory Committees*). Involvement includes, but is not limited to:

- Providing input into the Beacon medical necessity criteria
- Providing *peer review* and feedback on proposed practice guidelines, clinical quality monitors and indicators, new technology and any critical issues regarding *policies and procedures* of Beacon
- Reviewing *QIAs* and making recommendations to improve quality of clinical care and services
- Reviewing, evaluating, and making recommendations for the credentialing and re-credentialing of *participating practitioners and organizational providers*
- Reviewing, evaluating and making recommendations regarding sanctions that result from *participating practitioner and organizational provider* performance issues

As part of the QMP, Beacon incorporates principles designed to encourage the provision of care and treatment in a culturally competent and sensitive manner. These principles include:

- Emphasis on the importance of culture and diversity
- Assessment of cross-cultural relations
- Expansion of cultural knowledge
- Consideration of sex and gender identity
- Adaptation of services to meet the specific cultural and linguistic needs of *members*.

Participating providers are reminded to take the cultural background and needs of *members* into account when developing treatment plans and/or providing other services.

13.04 Quality Performance Indicator Development and Monitoring Activities

A major component of the quality management process is the identification and monitoring of meaningful companywide Key Performance Indicators (KPI) that are established, collected, and reported for a small but critical number of performance measures across Regions or Engagement Centers and all functional areas of the company. These core performance indicators are selected by functional area leads along with associated goals or benchmarks and are approved by senior management. KPIs are reported to the Executive Leadership Team (ELT), Corporate Quality Committee (CQC), and/or Corporate Medical Management Committee (CMMC) at least annually.

All functional areas are responsible for prioritizing their resources to meet or exceed performance goals or benchmarks established for each indicator. When performance is identified below established goals and/or trends, a corrective action plan is established to improve performance.

Beacon Regions or Engagement Centers are expected to identify, track, and trend local core performance indicators relevant to the populations they serve. Client performance reporting requirements may also be required. In any case, behavioral health care access and service performance is monitored regularly, including, but not limited to:

- Access and *availability* to behavioral health services
- Telephone service factors
- Utilization decision timeliness, adherence to *medical necessity*, and regulatory requirements
- *Member* and provider *complaints* and *grievances*
- *Member* and provider satisfaction with program services
- Nationally recognized or locally prescribed care outcome indicators such as HEDIS measures whenever possible
- Potential member safety concerns, which are addressed in the Member Safety Program section of this handbook, include
 - Serious reportable events (SREs) as defined by the National Quality Forum (NQF) and Beacon, and
 - Trending Events (TEs)

13.05 Service Availability and Access to Care

Beacon uses a variety of mechanisms to measure *member's* access to care with *participating practitioners*. Unless other appointment *availability* standards are required by a specific client or government-sponsored health benefit program, service *availability* is assessed based on the following standards for participating practitioners:

- An individual with life-threatening *emergency* needs is seen immediately
- An individual with non-life-threatening *emergency* needs is seen within six (6) hours
- An individual with *urgent* needs is seen within 48 hours
- *Routine* office *visits* are available within 10 business days
- *Routine follow-up* office *visits* for non-prescribers are available within 30 business days of initial visit
- *Routine follow-up* office *visits* for prescribers are available within 90 business days of initial visit

The following methods may be used to monitor *participating provider* behavioral health service *availability* and *member* access to care:

- Analysis of *member complaints* and *grievances* related to *availability* and access to care
- *Member* satisfaction surveys specific to their experience in accessing care and routine appointment availability
- Open shopper staff surveys for appointment availability—an approach to measuring timeliness of appointment access in which a surveyor contacts *participating provider's* offices to inquire about appointment availability and identifies from the outset of the call that he or she is calling on behalf of Beacon
- Referral line calls are monitored for timeliness of referral appointments given to *members*
- Analysis and trending of information on appointment availability obtained during site visits
- Analysis of call statistics (e.g., average speed of answer, abandonment rate over five seconds)
- Annual Geo-Access and network density analysis (see Network *policies and procedures*)

In addition to these monitoring activities, *participating providers* are required by contract to report to network management when they are at capacity. This assists customer service in selecting appropriate, available *participating* practitioners for *member* referral.

13.06 Healthcare Effectiveness Data and Information Set (HEDIS^{®6})

There are a number of ways to monitor the treatment of individuals with mental health and/or substance use conditions receive. Many of you who provide treatment to these individuals measure your performance based on quality indicators such as those to meet CMS reporting program requirements; specific state or insurance commission requirements; managed care contracts; and/or internal metrics. In most cases there are specific benchmarks that demonstrate the quality that you strive to meet or exceed.

Beacon utilizes a number of tools to monitor population-based performance in quality across regions, states, lines of business and diagnostic categories. One such tool is the Healthcare Effectiveness Data and Information Set (HEDIS) behavioral health best practice measures as published by the National Committee for Quality Assurance (NCQA) as one of our tools. Like the quality measures utilized by CMS, Joint Commission, and other external stakeholders, these measures have specific, standardized rules for calculation and reporting. The HEDIS measures allow consumers, purchasers of health care and other stakeholders to compare performance across different health plans.

While the HEDIS measures are population-based measures of our partner health plan performance and major contributors to health plan accreditation status, our partner health plans rely on us to ensure behavioral health measure performance reflects best practice. Our providers are the key to guiding their patient to keep an appointment after leaving an inpatient psychiatric facility; taking their antidepressant medication or antipsychotic medication as ordered; ensuring a child has follow up visits after being prescribed an ADHD medication; and ensuring an individual with schizophrenia or bipolar disorder has annual screening for diabetes and coronary heart disease.

There are six domains of care and service within the HEDIS library of measures:

1. Effectiveness of Care
2. Access and Availability

6 HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

3. Utilization and Relative Resource Use
4. Measures Collected Using Electronic Clinical Data Systems (ECDS)
5. Experience of Care
6. Health Plan Descriptive Information

A brief description of these measures:

1. **Effectiveness of Care:** Measures that are known to improve how effective care is delivered. One very important measure in this domain is Follow-up after Mental Health Hospitalization (Aftercare). In effect, this means how long someone waits to get mental health care after they are discharged from an inpatient mental health hospital. To prevent readmission and help people get back into the community successfully, best practice is from seven to thirty days after discharge.
2. **Access/Availability:** Measures how quickly and frequently members receive care and service within a specific time. For example, the Initiation and Engagement of Drug and Alcohol Abuse Treatment measure relies on frequency and timeliness of treatment to measure treatment initiation and treatment engagement. Studies show that an individual who engages in the treatment process have better outcome and success in recovery and sobriety.
3. **Utilization and Relative Resource Use:** This domain includes evidence related to the management of health plan resources and identifies the percentage of members using a service. For example, Beacon measures Mental Health Utilization and Plan All Cause Readmissions.
4. **Measures Collected Using Electronic Clinical Data Systems (ECDS):** This is the newest domain, and it requires calculation of outcomes by accessing data through the electronic submission of a member's electronic health record (EHR). An example of an ECDS measure is the Utilization of the PHQ-9. This demonstrates whether a PHQ-9 was administered to a patient with depression four months after initiation of treatment to measure response to treatment.
5. **Experience of Care:** This domain is specific to health plans.
6. **Health Plan Descriptive Information:** We supply Board Certification of physicians and psychologists to the plan; all other information is specific to the health plan.

Below is a brief description of the HEDIS measures that apply to the behavioral health field requirements associated with each:

1. Follow-up after Hospitalization for Mental Illness

Best practice for a member aged six or older to transition from acute mental health treatment to the community is an appointment with a licensed mental health practitioner (outpatient or intermediate treatment) within seven and/or 30 calendar days of discharge.

For this measure, NCQA requires organizations to substantiate by documentation from the *member's* health record all nonstandard supplemental data that is collected to capture missing service data not received through claims, *encounter* data, laboratory result files, and pharmacy data feeds. Beacon requires proof-of-service documentation from the *member's* health record that indicates the service was received. All proof-of-service documents must include all the data elements required by the measure. Data elements included as part of the patient's legal medical record are:

- Member identifying information (name and DOB or member ID)
- Date of service

- DSM diagnosis code
- Procedure code/Type of service rendered
- Provider site/facility
- Name and licensure of mental health practitioner rendering the service
- Signature of rendering practitioner, attesting to the accuracy of the information

The critical pieces of this measure for *providers/participating providers* are:

- **Inpatient facilities** need to:
 - Use accurate diagnoses when submitting claims for inpatient treatment. If the *diagnosis* on admission is a mental health *diagnosis* but subsequent evaluation during the stay confirms that the primary *diagnosis* is substance use, please use the substance use *diagnosis* on the claim submitted at discharge.
 - Ensure that discharge planners educate patients about the importance of aftercare for successful transition back to their communities.
 - Ensure that follow-up *visits* are within seven calendar days of discharge. **Note:** It is important to notify the *provider/participating providers* that the appointment is post hospital discharge and that an appointment is needed in seven calendar days.
 - Ensure that the appointment was made with input from the patient. If the member has a pre-existing provider and is agreeable to going back to that provider schedule the appointment with that provider. If not, the location of the outpatient provider or PHP, IOP or other alternative level of care, must be approved by the member and be realistic and feasible for the member to keep that appointment.
- **Outpatient *providers/participating providers*** need to make every attempt to schedule appointments within seven calendar days for *members* being discharged from inpatient care. *Providers/participating providers* are encouraged to contact those *members* who are “no show” and reschedule another appointment.

2. Initiation and Engagement of Alcohol and other Drug Use Treatment

This measure aims to define best practice for initial and early treatment for substance use disorders by calculating two rates using the same population of *members* who receive a new diagnosis of Alcohol and Other Drug (AOD) use from any provider (ED, Dentist, PCP, etc.):

- **Initiation of AOD Use Treatment:** The percentage of adults diagnosed with AOD Use who initiate treatment through either an inpatient AOD admission or an outpatient service for AOD from a substance use provider AND an additional AOD service within 14 calendar days.
- **Engagement of AOD Treatment:** An intermediate step between initially accessing care and completing a full course of treatment. This measure is designed to assess the degree to which the *members* engage in treatment with two additional AOD services within 30 calendar days after initiation phase ends. The services that count as additional AOD services include IOP, Partial Hospital, or outpatient treatment billed with *CPT-4* or revenue codes associated with substance use treatment.

3. Antidepressant Medication Management (AMM)

The components of this measure describes best practice in the pharmacological treatment of newly diagnosed depression treated with an antidepressant by any provider by measuring the length of time the member remains on medication. There are two treatment phases:

- **Acute Phase:** The initial period of time the member must stay on medication for the majority of symptoms to elicit a response is 12 weeks
- **Continuation Phase:** The period of time the member must remain on medication in order to maintain the response is for at least six months.

4. Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

The components of this measure describes best practice in the pharmacological management of children 6-12 years newly diagnosed with ADHD and prescribed an ADHD medication by measuring the length of time between initial prescription and a follow up psychopharmacology visit and the continuation and maintenance phases of treatment.

- **Initiation Phase:** For children, 6-12 years of age, newly prescribed ADHD medication best practice requires a follow up visit with a prescriber within 30 days of receiving the medication.

For ongoing treatment with an ADHD medication, best practice requires:

- **Continuation and Maintenance (C&M) Phase:** At least two additional follow-up visits with a prescriber in the preceding nine months; and, the child remains on the medication for at least seven months.

5. Diabetes Screening for People with Bipolar Disorder or Schizophrenia Who Are Using Antipsychotic Medications (SSD)

For *members* with Schizophrenia or Bipolar diagnosis who were being treated with an antipsychotic medication, this measure monitors for potential Type 2 Diabetes with an HbA1C test.

6. Diabetes Monitoring for People with Diabetes and Schizophrenia Who are Using Antipsychotic Medications (SMD)

For members who have Type 2 Diabetes, a Schizophrenic or Bipolar diagnosis and are being treated with an antipsychotic this measure's best practice is an annual or more frequent LDL-C test and an HbA1c test (SMD).

7. Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)

For members with Schizophrenia or Bipolar diagnosis who are being treated with an antipsychotic medication this measure monitors for potential cardiac disease with a LDL-C test.

8. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)*

This measure is described as the percentage of *members* 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

9. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

For child and adolescent members (1-17) prescribed antipsychotic medication on an ongoing basis, best practice requires testing at least annually during the measurement year to measure glucose levels (Blood Glucose or HbA1C) and cholesterol levels to monitor for development of metabolic syndrome.

10. Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)

This measure identifies children and adolescents who are on two or more concurrent antipsychotic medications.

The best practice here is that multiple concurrent use of antipsychotic medications is not best practice nor approved by the FDA. While there are specific situations where a child or adolescent requires concurrent medications, the risk/benefit of the treatment regime must be carefully considered and monitoring in place to prevent adverse outcome.

11. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

For children and adolescents with a new prescription for an antipsychotic, best practice requires that the child receive psychosocial care as part of first line treatment.

First line treatment is associated with improved outcomes and adherence.

12. Utilization of the PHQ-9 to Monitor Depression for Adolescents and Adults (DMS)

For members diagnosed with depression treated in outpatient settings the PHQ-9 or PHQ-A (adolescent tool) must be administered by the outpatient provider at least once during a four-month treatment period.

13. Depression Remission or Response for Adolescents and Adults (DRR)

The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within five to seven months of the elevated score. Four rates are reported:

- **ECDS Coverage.** The percentage of members 12 and older with a diagnosis of major depression or dysthymia, for whom a health plan can receive any electronic clinical quality data.
- **Follow-Up PHQ-9.** The percentage of members who have a follow-up PHQ-9 score documented within the five to seven months after the initial elevated PHQ-9 score.
- **Depression Remission.** The percentage of members who achieved remission within five to seven months after the initial elevated PHQ-9 score.
- **Depression Response.** The percentage of members who showed response within five to seven months after the initial elevated PHQ-9 score.

Note: These measures are collected utilizing Electronic Clinical Data Sets (ECDS) as found in the provider's Electronic Medical Record. While NCQA/HEDIS is looking to expand the options for collecting this data, Beacon has yet to begin discussing this requirement with providers.

14. Follow-up After Emergency Department Visit for Mental Illness (FUM)

The percentage of emergency department (ED) visits for members six years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported:

- Follow-up visit to occur within seven days of ED discharge.
- If the seven-day visit goal is missed, the next goal is a visit within 30 days of ED discharge.

15. Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA)

The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) dependence, who had a follow up visit for AOD. Two rates are reported:

- Follow-up visit to occur within seven days of ED discharge.
- If the seven-day visit goal is missed, the next goal is a visit within 30 days of ED discharge.

Here is the complete list of HEDIS Behavioral Health measures:

Effectiveness of Care:

- **AMM:** Antidepressant Medication Management
- **ADD:** Follow-Up Care for Children Prescribed ADHD Medication
- **FUH:** Follow-Up After Hospitalization for Mental Illness
- **SSD:** Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- **SMD:** Diabetes Monitoring for People with Diabetes and Schizophrenia
- **SMC:** Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
- **SAA:** Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- **APC:** Use of Multiple Concurrent Antipsychotics in Children and Adolescents
- **APM:** Metabolic Monitoring for Children and Adolescents on Antipsychotics
- **FUM:** Follow-up After Emergency Department Visit for Mental Illness
- **FUA:** Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence

Other Domains:

Access and Availability

- **IET:** Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- **APP:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Utilization/Relative Resource Use - Utilization

- **PCR:** Plan All-Cause Readmissions
- **IAD:** Identification of Alcohol and Other Drug Services
- **MPT:** Mental Health Utilization

Health Plan Descriptive Information

- **BCR:** Board Certification

Electronic Clinical Data Systems

- **DMS:** Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults
- **DRR:** Depression Remission or Response for Adolescents and Adults

13.07 Continuity and Coordination of Care

Beacon monitors continuity and *coordination of care* throughout its continuum of behavioral health services. Monitoring may include reviews and audits of treatment records, coordination of discharge planning between inpatient and outpatient *providers/participating providers*, and monitoring *provider/participating provider* performance on pre-determined *coordination of care* indicators. Processes are established seeking to avoid disruption of care for the *member* when there is a change in their treating *provider/participating provider*. Such changes may include, but are not limited to:

- A *member* requires a change in *level of care*, necessitating a new *participating provider*
- There are multiple *providers/participating providers* involved in treatment simultaneously (psychiatrist for medication management, therapist for on-going treatment)
- A change in health plans or benefit plans
- Termination of a *participating provider*
- A *member* is being treated for several (co-morbid) conditions simultaneously with multiple *providers/participating providers* (both behavioral health specialists, primary care, medical specialists, or providers specializing in developmental disabilities)

13.08 Screening Programs

Beacon supports the early detection and treatment of depressive and comorbid disorders to promote optimal health for members 13 years and older.

A few helpful reminders:

- Beacon offers many screening tools and programs available at no cost:
 - [PCP/ Provider Toolkit](#)
 - [Depression Screening Program](#) (PDF)
 - [Comorbid Mental Health and Substance Use Disorder Screening Program](#) (PDF)
- Use screening tools at the first visit and repeat at regular intervals as clinically indicated to identify potential symptoms that may need further evaluation.
- Depression
 - Patient Health Questionnaire 9 (PHQ-9) is a brief, multi-purpose tool for assessing depression, and is available in [English](#), [Spanish](#), and a variety of other languages in [Beacon's PCP/ Provider Toolkit](#).
 - When assessing for depression, remember to rule out bipolar disorders; you may choose to use the [Mood Disorder Questionnaire \(MDQ\)](#).
- Suicide
 - Beacon endorses the National Action Alliance for Suicide Prevention's [Recommended Standard Care for People with Suicide Risk](#), which screens individuals for suicide and includes a list of screening tools in the Appendix.
- Comorbid issues
 - Remember to screen for possible mental health disorders when a diagnosis of a substance use disorder is present and conversely to screen for a potential substance use disorder when a mental health disorder is present.

The [CRAFFT Screening Interview](#) (PDF) assesses for substance use risk specific to adolescents.

Learn more about [Beacon's Depression Screening Program](#) and [Comorbid Screening Program](#) at the attached links.

13.09 Treatment Record Standards and Guidelines

Member treatment records should be maintained in compliance with all applicable medical standards, privacy laws, state and federal rules and regulations, as well as Beacon's *policies and procedures* and in a manner that is current, comprehensive, detailed, organized and legible to promote effective patient care and quality review. Providers are encouraged to use only secure electronic medical record technology when available. Beacon's *policies and procedures* incorporate standards of accrediting organizations to which Beacon is or may be subject (e.g., NCQA and URAC), as well as the requirements of applicable state and federal laws, rules, and regulations.

References to 'treatment records' mean the method of documentation, whether written or electronic, of care and treatment of the *member*, including, without limitation, medical records, charts, medication records, physician/practitioner notes, test and procedure reports and results, the treatment plan, and any other documentation of care and/or treatment of the *member*.

Progress notes should include what psychotherapy techniques were used, and how they benefited the *member* in reaching his/her treatment goals. Progress notes do not have to include intimate details of the *member's* problems but should contain sufficient documentation of the services, care, and treatment to support *medical necessity* of same. Intimate details documenting or analyzing the content of conversations during a private counseling session or a group, joint, or family counseling session should be maintained within the psychotherapy notes and kept separate from the *member's* treatment record made available for review and audit.

Member treatment record reviews and audits are based on the record keeping standards set out below:

- Each page (electronic or paper) contains the member's name or identification number.
- Each record includes the member's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant.
- All entries in the treatment record are dated and include the responsible clinician's name, professional degree, and relevant identification number (if applicable), and modality of treatment (office-based or telehealth (if telehealth video, phone or other modality). The length of the visit/session is recorded, including visit/session start and stop times.
- Reviews may include comparing specific entries to billing claims as part of the record review.
- The record, when paper based is legible to someone other than the writer.
- Medication allergies, adverse reactions and relevant medical conditions are clearly documented and dated. If the member has no known allergies, history of adverse reactions or relevant medical conditions, this is prominently noted.
- Presenting problems, along with relevant psychological and social conditions affecting the member's medical and psychiatric status and the results of a mental status exam, are documented.

- Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented, and revised in compliance with written protocols.
- Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.
- A medical and psychiatric history is documented, including previous treatment dates, practitioner identification, therapeutic interventions and responses, sources of clinical data, and relevant family information.
- For children and adolescents, past medical and psychiatric history includes prenatal and perinatal events (when available), along with a developmental history (physical, psychological, social, intellectual and academic).
- For members 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over-the-counter drugs.
- A DSM (or the most current version of the DSM) diagnosis is documented, consistent with the presenting problems, history, mental status examination, and/or other assessment data.
- Treatment plans are consistent with diagnoses, have both objective, measurable goals and estimated timeframes for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable.
- Treatment plans are updated as needed to reflect changes/progress of the member.
- Continuity and coordination of care activities between the primary clinician, consultants, ancillary providers, and health care institutions are documented as appropriate.
- Informed consent for medication and the member's understanding of the treatment plan are documented.
- Additional consents are included when applicable (e.g., alcohol and drug information releases).
- Progress notes describe the member's strengths and limitations in achieving treatment plan goals and objectives and reflect treatment interventions that are consistent with those goals and objectives.
- Documented interventions include continuity and coordination of care activities, as appropriate.
- Dates of follow-up appointments or, as applicable, discharge plans are noted.

In addition to other requests for *member* treatment records included in this *handbook* and/or the *provider agreement*, *member* treatment records are subject to targeted and/or unplanned reviews by the Beacon Quality Management Department or its designee, as well as audits required by state, local, and federal regulatory agencies and *accreditation* entities to which Beacon is or may be subject to.

13.10 Treatment Record Reviews

Participating providers are required to cooperate with treatment record reviews and audits conducted by Beacon and associated requests for copies of *member* records. For the purpose of conducting retrospective case reviews, treatment records for Beacon *members* should be maintained for the time period(s) required by applicable state and/or federal laws and/or regulations, and as detailed in the *provider agreement*.

Beacon may conduct treatment record reviews and/or audits:

- On an unplanned basis as part of *continuous quality improvement* and/or monitoring activities
- As part of routine quality and/or billing audits
- As may be required by clients of beacon
- In the course of performance under a given client contract
- As may be required by a given government or regulatory agency
- As part of periodic reviews conducted pursuant to *accreditation* requirements to which Beacon is or may be subject
- In response to an identified or alleged specific quality of care, professional competency or professional conduct issue or concern
- As may be required by state and/or federal laws, rules, and/or regulations
- In the course of claims reviews and/or audits
- As may be necessary to verify compliance with the *provider agreement*
- Beacon treatment record standards and guidelines for *member* treatment record reviews conducted as part of quality management activities are set out in the quality management section of this *handbook*.

Treatment record reviews and/or audits may be conducted through on-site reviews in the *participating provider's* office or facility location, and/or through review of electronic or hard copy of documents and records supplied by the *participating provider*. Unless otherwise specifically provided for in the *provider agreement* and/or other sections of this *handbook* with respect to a particular type of record review or audit, *participating providers* must supply copies of requested records to Beacon within five business days of the request.

Beacon will use and maintain treatment records supplied by *participating providers* for review and/or audit in a confidential manner and in accordance with applicable laws and regulations regarding the privacy or confidentiality of *protected health information* and/or patient identifying information. Never send original records as they will not be returned at the completion of the review or audit. Only send those sections of the record that are requested. Unless otherwise specifically provided in the *provider agreement*, access to and any copies of *member* treatment records requested by Beacon or designees of Beacon shall be at no cost. Records are reviewed by licensed clinicians. Treatment records reviews and/or audits conducted as part of Quality Management activities include application of an objective instrument(s). The instrument(s) are reviewed at least annually; Beacon reserves the right to alter/update, discontinue and/or replace such instruments in its discretion and without notice.

Following completion of treatment record reviews and/or audits, Beacon will give the *participating provider* a written report that details the findings. If necessary, the findings report will include a corrective action plan with specific recommendations that will enable the *participating provider* to more fully comply with Beacon standards for treatment records.

Participating providers will grant access for *members* to the *member's* treatment records upon written request and with appropriate identification. *Participating providers* should review *member* treatment records prior to granting access to *members* to ensure that confidential information about other family members and/or significant others that may be referenced and/or included therein is redacted.

13.11 Member Safety Program

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

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

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

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

1. Surgical or Invasive Procedures (i.e., wrong site, wrong patient, wrong procedure, foreign object, and death of ASA class 1 patient)
2. Product or Device Events (i.e., contamination, device malfunction, and embolism)
3. Patient Protection Events (i.e. discharge of someone unable to make decisions, elopement, completed suicide, attempted suicide, and self-injurious behaviors)
4. Care Management Events (i.e., medication error, fall)
5. Environmental Events (i.e., electric shock, gas, burn, restraint, seclusion, restrictive interventions)
6. Potential Criminal Events (i.e., impersonation, abduction, physical assault, and sexual behavior)
7. Beacon Specific (such as disaster management, accidents, staff misconduct, standards of care, and natural death)

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

- Provider inappropriate/unprofessional behavior
 - Inappropriate boundaries/relationship with member
 - Practitioner not qualified to perform services
 - Aggressive behavior

- Displays signs of cognitive, mental health, or substance use concerns impacting the care being provided
- Clinical practice-related issues
 - Abandoned member or inadequate discharge planning
 - Timeliness, accuracy, or adequacy of diagnosis, assessment, or referral
 - Delay in treatment
 - Effectiveness of treatment
 - Failure to coordinate care or follow clinical practice guidelines
 - Failure to involve family in treatment when appropriate
 - Medication error or reaction
 - Treatment setting not safe
- Access to care-related issues
 - Failure to provide appropriate appointment access
 - Lack of timely response to telephone calls
 - Prolonged in-office wait time or failure to keep appointment
 - Provider non-compliant with American Disabilities Act (ADA) requirements
 - Services not available or session too short
- Attitude and service-related issues
 - Failure to allow site visit
 - Failure to maintain confidentiality
 - Failure to release medical records
 - Fraud and abuse
 - Lack of caring/concern or poor communication skills
 - Poor or lack of documentation
 - Provider/staff rude or inappropriate attitude
- Other monitored events
 - Adverse reaction to treatment
 - Failure to have or follow communicable disease protocols
 - Human rights violations
 - Ingestion of an unauthorized substance in a treatment setting
 - Non-serious injuries (including falls)
 - Property damage and/or fire setting
 - Sexual behavior

Participating providers are required to report to Beacon within 24 hours all Potential Quality of Care (PQOC) concerns involving *members*. Beacon investigates Potential Quality of Care Concerns (PQOC) and uses the data generated to identify opportunities for improvement in the clinical care and service members receive. Beacon tracks and trends PQOC concerns and when necessary, investigates patterns or prevalence of incidents and uses the data generated to identify opportunities for quality improvement.

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

13.12 Professional Review/Fair Hearing Process

Individual *providers/participating providers*, where required by applicable law, may request a second level of *appeal/a fair hearing* when the PAC denies credentialing or re-credentialing, issues a sanction, or recommends termination of participation status of the *provider* from the Beacon provider network, where such denial, sanction, or recommendation is based on quality of care issues and/or issues related to professional competence or professional conduct. Information about the *fair hearing* process is located in the *appeals* section of this *handbook*.

13.13 Quality Improvement Activities/Projects

One of the primary goals of Beacon's National Quality Management Program (QMP) is to continuously improve care and services. Through data collection, measurement and analysis, aspects of care and service that demonstrate opportunities for improvement are identified and prioritized for *quality improvement* activities. Data collected for *quality improvement* projects and activities are frequently related to key industry measures of quality that tend to focus on high-volume diagnoses or services and high-risk or special populations. Data collected are valid, reliable and comparable over time. Beacon takes the following steps to ensure a systematic approach to the development and implementation of *quality improvement* activities:

- Monitoring of clinical quality indicators
- Review and analysis of the data from indicators
- Identification of opportunities for improvement
- Prioritization of opportunities to improve processes or outcomes of behavioral health care delivery based on *risk assessment*, ability to impact performance, and resource availability
- Identification of the affected population within the total membership
- Identification of the measures to be used to assess performance
- Establishment of performance goals or desired level of improvement over current performance
- Collection of valid data for each measure and calculation of the baseline level of performance
- Thoughtful identification of interventions that are powerful enough to impact performance
- Analysis of results to determine where performance is acceptable and, if not, the identification of current barriers to improving performance

13.14 Experience Surveys (formerly known as Satisfaction Surveys)

When delegated, Beacon, either directly or through authorized designees, conducts some form of experience survey to identify areas for improvement as a key component of the QMP. Experience survey participation may include *members*, *participating providers*, and/or clients.

Member experience surveys measure opinions about clinical care, *participating providers*, and Beacon administrative services and processes. *Members* are asked to complete satisfaction surveys at various points in the continuum of care and/or as part of ongoing *quality improvement* activities. The results of these *member* surveys are summarized on an annual basis. Where appropriate, corrective actions are implemented in the Beacon functional department or as applicable in the Region.

Annual *participating provider* satisfaction surveys measure opinions regarding clinical and administrative practices. The results of *participating provider* surveys are aggregated and used to identify potential improvement opportunities within Beacon and possible education or training needs for *participating providers*. Where appropriate, corrective actions are implemented in the Beacon functional department or as applicable in the Region.

13.15 Member Complaints and Grievances

One method of identifying opportunities for improvement in processes at Beacon is to collect and analyze the content of *member complaints*. The Beacon *complaints* and grievance process has been developed to provide a structure for timely responses and to track and trend *complaint* and grievance data by type/category. *Complaint* and grievance data is compiled and reported to the local clinical quality committees at least semi-annually.