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

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

Behavioral Health Policy and Procedure Manual for Providers

WellSense Health Plan

This document contains chapters 1-8 of Beacon's Behavioral Health Policy and Procedure Manual for providers serving WellSense Health Plan members. The materials referenced within this manual are available on beacon's website. To obtain a copy, please e-mail provider.relations@beaconhealthoptions.com or call 866.444.5155.

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Chapter 1

Introduction

1.1. Beacon/WellSense Health Plan Partnership

The WellSense Health Plan (WellSense Health Plan or health plan) has contracted with Beacon Health Strategies LLC (Beacon), a Beacon Health Options company, to manage the delivery of mental health and substance use disorder services for all WellSense Health Plan members. The health plan delegates the following areas of responsibility to Beacon:

- Claims processing and claims payment
- Call Center Management
- Member rights and responsibilities
- Member connections
- Provider contracting and credentialing
- Quality management and improvement
- Service authorization
- Utilization management

1.2. About this Provider Manual

This Behavioral Health Provider Policy and Procedure Manual (hereinafter, the "Manual") is a legal document incorporated by reference as part of each provider's Provider Services Agreement (PSA) with Beacon. The Manual serves as an administrative guide outlining Beacon's policies and as follows:

- Chapter 1: Introduction
- Chapter 2: Medicare and Medicaid Requirements
- Chapter 3: Provider Participation in Beacon's Behavioral Health Services Network
- Chapter 4: Members, Benefits, and Member-Related Policies
- Chapter 5: Quality Management and Improvement Program
- Chapter 6: Utilization Management and Case Management
- Chapter 7: Clinical Reconsideration and Appeals
- Chapter 8: Billing Transactions

The Manual is posted on Beacon's website, www.beaconhealthoptions.com, and on Beacon's eServices. Providers may request a printed copy of the Manual by calling Beacon at 866.444.5155.

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

1.3. Introduction to WellSense Health Plan

WellSense Health Plan is a 501(c)(3) status managed care organization providing coverage to Commercial, MassHealth (Medicaid), and Senior Care Options (SCO) members. Founded in 1997 by Boston Medical Center, the plan contracts with providers and hospital systems throughout Massachusetts to deliver care to more than 240,000 members.

1.4. Introduction to Beacon Health Strategies LLC

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

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

1.5. Beacon/WellSense Health Plan Behavioral Health Program

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

1.6. Commonwealth of Massachusetts: Children's Behavioral Health Initiative

The Children's Behavioral Health Initiative (CBHI) is an undertaking of the Executive Office of Health and Human Services and MassHealth, along with the Massachusetts managed care entities, to implement a behavioral health system of care targeted at the needs of children in the Commonwealth. It encompasses:

- Improved education and outreach to MassHealth members; providers; members of the public; and private and state agency staff who come in contact with MassHealth members for early periodic screening, diagnosis, and treatment (EPSDT) services
- Implementation of standardized behavioral health assessments for eligible members who use behavioral health services
- Development of an information technology system known as the Virtual Gateway to track assessments, treatment planning, and treatment delivery
- Requirement to seek federal approval to cover several new or improved community-based services Beacon and WellSense Health Plan are full and active participants in CBHI. All behavioral health services created under CBHI are contracted with Beacon and available to serve WellSense Health Plan MassHealth members under age 21; some CBHI services are available to all Medicaid and Commercial youth.

  For more information on the court order, and the elements of the Commonwealth's remedy plan, please visit the CBHI website at http://www.mass.gov/eohhs/gov/commissions-and-initiatives/CBHI/ and Beacon's CBHI webpage.

1.7. Additional Information

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

- Go to the Provider Tools page of Beacon's website for detailed information about working with Beacon, frequently asked questions (FAQs), clinical articles, clinical practice guidelines, and links to additional resources.
- Call Beacon at 866.444.5155, to check member eligibility, number of visits available and applicable co-payments, confirm authorization, and get claim status.
- Log on to eServices to check member eligibility and number of visits available, submit claims and authorization requests, view claims and authorization status, view/print claims reports, update practice information, and use other electronic tools for communication and transactions with Beacon.
- E-mail provider.relations@beaconhealthoptions.com
- Beacon contact information is available on Beacon's website or call 866.444.5155.
- For benefit and other administrative information pertaining to medical/surgical care, visit www.WellSense.org or call WellSense Health Plan at 888.566.0008.

Chapter 2

Medicare and Medicaid Requirements

2.1. About this Chapter

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

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

2.2. Provider Requirements

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

- Not distribute any marketing materials, as such term is defined in 42 CFR Section 422.2260, to Medicare Advantage members or prospective Medicare Advantage members unless such materials have received the prior written approval of Beacon and, if required, CMS and/or the applicable plan. The provider shall further not undertake any activity inconsistent with CMS marketing guidelines as in effect from time-to-time. [42 CFR 422.2260, et seq.]
- Ensure that covered services are provided in a culturally competent manner. [42 CFR 422.112(a)(8)]
- Maintain procedures to inform Medicare Advantage members of follow-up care and, if applicable, provide training in self-care as necessary. [42.CFR 422.112(b)(5)]
- Document in a prominent place in the medical record of Medicare Advantage members if the member has executed an advance directive. [42 CFR 422.128(b)(1)(ii)(e)]
- Provide continuation of care to Medicare Advantage members in a manner and according to time frames set forth in the PSA, and if CMS imposes additional continuation of care criteria or time frames applicable to Medicare Advantage members, the provider shall comply with such additional CMS requirements as well as any requirements set forth in the PSA. [42 CFR 422. 504(g)(2)(i) and (ii) and 42 CFR 422.504(g)(3)]
- In the event that the provider provides influenza and/or pneumococcal vaccines to patients, for any Medicare Advantage member, the provider shall provide such vaccines to Medicare Advantage members with no cost sharing. [42 CFR 422.100(g)(1) and (2)]
- Not discriminate against any Medicare Advantage member based upon the member's health status. [42 CFR 422.110(a)]

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

- Be accessible to Medicare Advantage members 24 hours per day, seven days per week when medically necessary. [42 CFR 422.112(a)(7)]
- Comply, as set forth in the PSA, with all applicable federal laws, including but not limited to, those federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse such as the False Claims Act and the federal anti-kickback statute. [42 CFR 422.504(h)(1)]
- Agree that Beacon and/or the applicable plan may notify all impacted Medicare Advantage members of the termination of the provider's participation in Beacon or the plan's provider network, as applicable. [42 CFR 422.111(e)]
- Disclose to CMS and to Beacon or the plan, quality and performance indicators, including disenrollment rates, member satisfaction rates and health outcomes to enable the plan to satisfy applicable CMS reporting requirements. [42 CFR 422.504 (f)(2)(iv)(A), (B), and (C)]
- Safeguard the privacy of any information that identifies a particular Member and maintain records in an accurate and timely manner. [42 CFR 422.118]
- Maintain and distribute to all employees and staff written standards of conduct that clearly state the provider's commitment to comply with all applicable statutory, regulatory, and Medicare program requirements (Code of Conduct) and require all employees and staff to certify that they have read, understand, and agree to comply with the standards. Require employees and staff to certify that in administering or delivering Medicare benefits, they are free of any conflict of interest as set forth in the provider's conflict of interest policy. [42 CFR 422.503(b)(4)(vi)(A), (E), and (F)] (Beacon may request annual certifications and documentation necessary to satisfy a regulatory audit of Beacon or the plan.) Comply with the requirements of the compliance programs (which include measures to prevent, detect, and correct Medicare non-compliance as well as measures to prevent, detect, and correct fraud, waste, and abuse) of plans that are Part C and Part D sponsors. Comply with and participate in, and require employees and staff to comply with and participate in, training and education given as part of the plan's compliance plan to detect, correct, and prevent fraud, waste, and abuse. [42 C.F.R. §422.503 and 42C.F.R. §423.504]
- Monitor employees and staff on a monthly basis against the List of Excluded Individuals and Entities posted by the Office of the Inspector General of the Department of Health and Human Services and any applicable State Office of the Inspector General on their respective websites, the Excluded Parties List System, and the System for Award Management. [42 CFR 422. 503(b)(4)(vi)(F)]

- Provide Beacon with written attestations documenting satisfaction of the requirements set forth above specific to the provider's Code of Conduct, compliance with the plan's fraud, waste, and abuse training, and the performance of monthly monitoring of employees and staff. [42 CFR 422.503(b)(4)(vi)(A), (C), and (D)] The provider further acknowledges that:
    - Beacon and/or plans may offer benefits in a continuation area for the members who move permanently out of the plan's service area. [42 CFR 422.54(b)]
    - Beacon and/or plans will make timely and reasonable payment to, or on behalf of, a Medicare Advantage member for emergency or urgently needed services obtained by a member from a noncontracted provider or supplier to the extent provided by 42 CFR 422.100(b)(1)(ii).
    - Though it may not be applicable to the services provided by the provider, the plan will make available, through direct access and/or without member cost share as, and to the extent required by CMS, outofarea renal dialysis services and certain other services, such as mammography, women's preventive services and certain vaccines. [42 CFR 422.100(b)(1)(iv), 42 CFR 422.100(g)(1) and (2)]

Chapter 3

Provider Participation in Beacon's Behavioral Health Services Network

3.1. Network Operations

Beacon's Network Operations Department, with Provider Relations, is responsible for the procurement and administrative management of Beacon's behavioral health provider network. As such, their role includes contracting, credentialing and provider relations functions. Representatives may be reached by emailing provider.relations@beaconhealthoptions.com, or by calling our National Provider Service Line between 8 a.m. and 8 p.m., Eastern Time (ET) Monday through Friday at 800.397.1630.

3.2. Contracting and Maintaining Network Participation

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

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

3.3. Electronic Transactions and Communications with Beacon

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

ELECTRONIC MEDIA

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

1. eServices

eServices, Beacon's secure Web portal, supports all provider transactions, while saving providers time, postage expense, billing fees, and reducing paper waste These services include:

Verify member eligibility and benefits

- View authorization status
- Update practice information
- Check number of visits available
- Submit claims
- Upload EDI claims to Beacon

- View claims status
- EDI acknowledgment and submission reports
- Submit authorization requests
- Pend authorization requests for internal approval
- View EDI upload history
- Access Beacon's provider manual

eServices is completely free to contracted providers and is accessible 24 hours a day 7 days a week through www.beaconhealthoptions.com. Many fields are automatically populated to minimize errors and improve claim approval rates on first submission. Claims status is available within two hours of electronic submission. All transactions generate printable confirmation, and transaction history is stored for future reference.

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

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

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

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

2. Electronic Data Interchange

Electronic data interchange (EDI) is available for claims submission and eligibility verification directly by the provider to Beacon or via an intermediary. Beacon accepts standard HIPAA 837 professional and institutional health care claim transactions and provides 835 remittance advice response transactions. For information about testing and set up for EDI, download Beacon's 837 & 835 companion guides. Beacon also offers member eligibility verification through the 270 and 271 transactions. For information about 270 and 271 transactions, download Beacon's 270 and 271 companion guide.

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

E-MAIL

Beacon encourages providers to communicate via e-mail (non-PHI content only). Beacon often uses e- mail as the quickest and most efficient method of communication to disperse information including, but not limited to monthly bulletins, quarterly surveys, and changes to regulatory requirements. Providers may contact Beacon via e-mail for a quick and convenient way to receive assistance and training regarding claims submission, training questions, etc. by contacting provider.relations@beaconhealthoptions.com. In order to receive these notices in the most efficient manner, we strongly encourage you to enter and update e-mail addresses and other key contact information for your practice through eServices.

COMMUNICATION OF MEMBER INFORMATION

In keeping with HIPAA requirements, providers are reminded that PHI should not be communicated via e-mail, other than through Beacon's eServices. PHI may be communicated by telephone or secure fax.

It is a HIPAA violation to include any patient identifying information or

PHI in non-secure e-mail through the internet.

3.4. Appointment Access Standards

The Massachusetts Division of Insurance (DOI), MassHealth, and the Health Connector monitor accessibility of appointments within our network, based on the following standards:

APPOINTMENT STANDARDS AND AFTER HOURS ACCESSIBILITY

TYPE OF CARE	APPOINTMENT MUST BE OFFERED:
Routine/Non-Urgent Services	Within 10 business days
Urgent Care	Within 48 hours
Emergency Services	Immediately; 24 hours a day, 7 days a week
ESP Services	Immediately; 24 hours a day, 7 days a week

Inpatient and 24-hour diversionary service must schedule an aftercare follow-up prior to a member's discharge. The appointment date must be within the following time frames:

TYPE OF CARE	APPOINTMENT MUST BE OFFERED
Non-24 Hour Diversionary	Within 2 calendar days
Psychopharmacology Services/ Medication Management	Within 14 calendar days

All Other Outpatient Services	Within 7 calendar days
Intensive Care Coordination (ICC)	Within 3 calendar days

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

3.5. Service Availability and Hours of Operation

Providers shall maintain a system of 24-hour on-call services for all members in treatment and shall ensure that all members in treatment are aware of how to contact the treating or covering providers after hours and during provider vacations.

Crisis intervention services must be available 24 hours a day, seven days a week. Outpatient facilities, physicians, and practitioners are expected to provide these services during operating hours. After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician, agency-affiliated staff, crisis team, or hospital emergency room.

In addition, outpatient providers should have services available Monday through Friday, from 9:00 a.m. to 5:00 p.m., at a minimum. Evening and/or weekend hours should also be available at least two days per week. Under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency.

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

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

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

REQUIRED NOTIFICATION

TYPE OF INFORMATION	METHOD OF NOTIFICATION	
	ESERVICES	E-MAIL
General Practice Information		
Change in address or telephone number of any services	Yes	Yes
Addition or departure of any professional staff	Yes	Yes
Change in linguistic capability, specialty, or program	Yes	Yes
Discontinuation of any covered service listed in Exhibit A of the provider's PSA	Yes	Yes
Change in licensure or accreditation of provider or any of its professional staff	Yes	Yes
Appointment Access		
Change in licensure or accreditation of provider or any of its professional staff	Yes (license)	Yes
Change in hours of operation	Yes	Yes
Is no longer accepting new patients	Yes	Yes
Is available during limited hours or only in certain settings	Yes	Yes
Has any other restrictions on treating members	Yes	Yes
Is temporarily or permanently unable to meet Beacon standards for appointment access	Yes	Yes
Other		
Change in designated account administrator for the provider's eServices accounts	No*	Yes
Merger, change in ownership, or change of tax identification number (As specified in the PSA, Beacon is not required to accept assignment of the PSA to another entity.)	No*	Yes

TYPE OF INFORMATION	METHOD OF NOTIFICATION	
	ESERVICES	E-MAIL
Adding a site, service, or program not previously included in the PSA; remember to specify: a. Location b. Capabilities of the new site, service, or program	No*	Yes

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

3.7. Beacon's Provider Database

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

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

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

3.8. Adding Sites, Services, and Programs

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

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

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

3.9. Provider Credentialing and Recredentialing

Beacon conducts a rigorous credentialing process for network providers based on CMS (Centers for Medicare & Medicaid Services) and NCQA (National Committee for Quality Assurance) guidelines. All providers must be approved for credentialing by Beacon in order to participate in Beacon's behavioral health services network, and must comply with recredentialing standards by submitting requested information within the specified time frame. Private, solo, and group practice clinicians are individually credentialed, while facilities are credentialed as organizations; the processes for both are described below.

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

CREDENTIALING PROCESSES

INDIVIDUAL PRACTITIONER CREDENTIALING	ORGANIZATIONAL CREDENTIALING
Beacon individually credentials and recredentials the following categories of clinicians in private solo or group practice settings: • Psychiatrist • Physician certified in addiction • Psychologist • Licensed clinical social workers • Master's level clinical nurse specialist/psychiatric nurse • Licensed behavioral health counselors • Licensed marriage and family therapists - Licensed chemical dependency professional • Advanced chemical dependency professional • Certified alcohol counselors • Certified alcohol and substance use/drug abuse counselors • Certified alcoholism/drug use counselors • Other behavioral healthcare specialists who are master's level of above and who are	Beacon credentials and recredentials facilities and licensed outpatient agencies as organizations. Facilities that must be credentialed by Beacon as organizations include: • Licensed outpatient clinics and agencies, including hospital-based clinics • Freestanding inpatient behavioral health facilities – freestanding and within general hospital • Inpatient mental health units at general hospitals • Inpatient detoxification facilities • CBHI programs: - Therapeutic Mentoring - In-Home Therapy - In-Home Behavioral Services - Family Support and Training (Family Partners) • Intensive Care Coordination (ICC)

| INDIVIDUAL PRACTITIONER CREDENTIALING | ORGANIZATIONAL CREDENTIALING |

licensed, certified, or registered by the state in which they practice	▪ Other diversionary mental health and substance use disorder services including: • Partial hospitalization • Day treatment • Intensive outpatient • Residential • Substance use rehabilitation

Individual Practitioner Credentialing

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

Once the practitioner has been approved for credentialing and contracted with Beacon as a solo provider or verified as a staff member of a contracted practice, Beacon will mail a welcome packet which will include an approval letter notifying the practitioner or the practice's credentialing contact of the date on which he or she may begin to serve members of specified health plans.

Organizational Credentialing

In order to be credentialed, facilities must be licensed or certified by the state in which they operate, and the license must be in force and in good standing at the time of credentialing or recredentialing. If the facility reports accreditation by The Joint Commission (TJC), Council on Accreditation of Services for Family and Children (COA), or Council on Accreditation of Rehabilitation Facilities (CARF), such accreditation must be in force and in good standing at the time of credentialing or recredentialing of the facility. If the facility is not accredited by one of these accreditation organizations, Beacon accepts a CMS/State site survey in lieu of accreditation. IF no CMS/State site survey exists, the organizational application will be reviewed for rural status (does not require site visits) or if appropriate, conducts a site visit prior to rendering a credentialing decision.

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

Behavioral health program eligibility criteria include the following:

- A master's degree or above in a mental health field (including, but not restricted to: counseling, family therapy, psychology, etc.) from an accredited college or university
- An employee or contractor within a hospital or mental health clinic licensed in the Commonwealth of Massachusetts that meets all applicable federal, state, and local laws and regulations
- Supervision in the provision of services by a licensed independent clinical social worker, a licensed psychologist, a licensed master's level clinical nurse specialist, or licensed psychiatrist meeting the contractor's credentialing requirements
- Coverage by the hospital or mental health/substance use disorder agency's professional liability coverage at a minimum of $1,000,000 each occurrence/$3,000,000 aggregate

- Absence of Medicare/Medicaid sanctions

The Contractor shall use, and shall require its providers to use, the OIG List of Excluded Individuals Entities (LEIE) upon initial hiring or contracting and on an ongoing monthly basis to screen employees and contractors, including providers and subcontractors, to determine whether any such individuals or entities are excluded from participation in federal health care programs. The Contractor shall notify EOHHS of any discovered exclusion of an employee or contractor.

CANS CERTIFICATION

In addition to the criteria noted above, clinicians—including private and facility-based practitioners—who provide behavioral health assessment and treatment to MassHealth members under age 21 must be trained and certified in the use of CANS. Recertification will be required every two years. If you have questions, e-mail mass.cans@umassmed.edu or call the University of Massachusetts CANS Training Program at 508.857.1116.

Providers must enter the CANS assessments into EOHHS' Virtual Gateway. All providers must have a Virtual Gateway account and a high speed internet or satellite internet connection to access the CANS IT system.

Providers must obtain member consent to enter the information gathered using the CANS Tool and the determination whether or not the assessed member is suffering from a serious emotional disturbance (SED) into the IT system. If consent is not obtained, providers are still required to enter the SED determination.

RECREDENTIALING

All practitioners and organizational providers are reviewed for recredentialing within 24 months of their last credentialing approval date (with the exception of in-network providers serving Commercial Massachusetts plans where recredentialing occurs every 36 months). They must continue to meet Beacon's established credentialing criteria and quality-of-care standards for continued participation in Beacon's behavioral health provider network. Failure to comply with recredentialing requirements, including timelines, may result in removal from the network.

3.10. Prohibition on Billing Members

WellSense Health Plan members may not be billed for any covered service or any balance after reimbursement by Beacon except for any applicable copayment, coinsurance and/or deductible.

MASSHEALTH/SENIOR CARE OPTIONS (SCO) MEMBERS

Providers may not charge members for any service:

1. That is not medically necessary MCO or non-MCO covered service
2. For which other MCO covered services or non-MCO covered services may be available to meet the member's needs
3. Where the provider did not explain items (a) and (b), that the member will be liable to pay the provider for the provision of any such services; the provider shall be required to document compliance with this provision

Further, providers may not charge MassHealth members for any services that are not deemed medically necessary upon clinical review or that are administratively denied. It is the provider's responsibility to check benefits prior to beginning treatment of this membership and to follow the procedures set forth in this manual.

COMMERCIAL MEMBERS

Providers may provide and obtain payment for non-covered services only from eligible Commercial members and only if the provider has obtained prior written acknowledgment from the member that such services are not covered and the member will be financially responsible.

3.11. Additional Regulations

According to 211 CMR 52.12(11), "[n]othing in 211 CMR 52.12 shall be construed to preclude a carrier from requiring a health care provider to hold confidential specific compensation terms."

According to 211 CMR 52.12(12), "[n]othing in 211 CMR 52.12 shall be construed to restrict or limit the rights of health benefit plans to include as provider's religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious non- medical providers."

Chapter 4

Members, Benefits, and Member-Related Policies

4.1. Mental Health and Substance Use Disorder Benefits

WellSense Health Plan offers benefit programs for MassHealth/Senior Care Options (SCO) and Commercial enrollees. The following levels of care are covered (unless noted), provided that services are medically necessary and delivered by contracted network providers:

- Inpatient Detoxification
- Substance Abuse Rehabilitation
- Inpatient Mental Health
- Outpatient Mental Health Treatment
- Outpatient Substance Use Disorder Treatment
- Crisis Stabilization Unit
- Partial Hospitalization Program
- Intensive Outpatient Program
- Ambulatory Detoxification
- Community Support
- Emergency Services
- Psychological and Neuropsychological Testing
- CBHI Services
- Autism Services
- Telehealth Services

OUTPATIENT BENEFITS

Access

WellSense Health Plan members may access outpatient mental health and substance use disorder services by self-referring to a network provider, by calling Beacon, or by referral through acute or emergency room encounters. Members may also access outpatient care by referral from their PCPs; however, a PCP referral is never required for behavioral health services.

Outpatient Benefit Summary

WellSense **MassHealth Members**

- Prior authorization is not required for routine outpatient services
- Co-payments do not apply

WellSense Senior Care Options (SCO) Members

- Prior authorization is not required for routine outpatient services
- Co-payments do not apply

WellSense Commercial Members

- Prior authorization is not required for routine outpatient services
- Co-payments are subject to change each plan year (copayments can be verified on eServices or by calling Beacon at 866.444.5155)

WellSense MassHealth, SCO, and Commercial Members

- Evaluation & Management (E&M) sessions and group therapy require no authorization.

Additional Benefit Information

- Benefits do not include payment for health care services that are not medically necessary
- Neither Beacon nor the health plan are responsible for the costs of investigational drugs or devices or the costs of non-healthcare services, such as the costs of managing research or the costs of collecting data that is useful for the research project but not necessary for the enrollee's care
- Authorization is required for all services except emergency services. See Chapter 6 for authorization procedures.

4.2. Member Rights and Responsibilities

MEMBER RIGHTS

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

Members must be fully informed of their rights to access treatment and to participate in all aspects of treatment planning. All health plan members have the following rights:

Right to Receive Information

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

Right to Respect and Privacy

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

Right to Confidentiality

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

Right to Participate in the Treatment Process

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

Right to a Second Opinion

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

Right to Treatment and Informed Consent

Members have the right to give or refuse consent for treatment and for communication to PCPs and other behavioral health providers. Members have the right to delegate their rights to speak or make medical decisions on their behalf.

Right to Clinical/Treatment Information

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

Right to Appeal Decisions Made by Beacon

Members and their legal guardian have the right to appeal Beacon's decision not to authorize care at the requested level of care, or Beacon's denial of continued stay at a particular level of care according to the clinical appeals procedures described in Chapter 7. Members and their legal guardians may also request the mental health or substance use disorder health care provider to appeal on their behalf according to the same procedures.

Right to Submit a Complaint or Grievance to Beacon

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

- The quality of care delivered to the member by a Beacon-contracted provider
- The Beacon utilization review process
- The Beacon network of services
- The procedure for filing a complaint or grievance as described in Chapter 5

Right to Contact Beacon

Members have the right to contact Beacon's Member Service Team to obtain a copy of Beacon's Member Rights and Responsibilities statement. The Beacon Member Service Team may be contacted at 888.217.3501 (MassHealth members) or 877.957.5600 (Commercial members) or by TTY at 711.

Right to Make Recommendations about Member Rights and Responsibilities

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

Claims and Billing

Members have the right to know the facts about any charge or bill they receive.

MEMBER RESPONSIBILITIES

Members of the health plan agree to do the following:

- Choose a primary care practitioner (PCP) and site for the coordination of all medical care; members may change PCPs at any time by contacting their health plan.
- Carry the health plan identification card and show the card whenever treatment is sought
- In an emergency, seek care at the nearest medical facility and call their PCP within 48 hours; the back of the health plan ID card highlights the emergency procedures
- Provide clinical information needed for treatment to their behavioral health care provider

- To the extent possible, understand their behavioral health problems and participate in the process of developing mutually agreed-upon treatment goals
- Follow the treatment plans and instructions for care as mutually developed and agreed-upon with their practitioners. If changes are made to the treatment plan the member is to communicate with the practitioner the changes changes.
- Members are responsible for understanding their benefits, what's covered and what's not covered. They are responsible for understanding that they may be responsible for payment of services received that are not included in the Covered Services List for their coverage type.
- Notify the plan and/or Beacon and the provider of changes such as address changes, phone number change, or change in insurance.

POSTING MEMBER RIGHTS OR RESPONSIBILITIES

All contracted providers must display in a highly visible and prominent place, a statement of member rights and responsibilities. This statement must be posted and made available in languages consistent with the demographics of the population(s) served. This statement can either be Beacon's statement or one of the statements listed below, based on facility licensure.

- **Department of Public Health (DPH)-licensed facilities** – Network facilities whose licenses are issued by DPH are required to post DPH's statement of human rights within the facility prominently, consistent with the primary language of the facility's membership.
- **All other network facilities** – Facilities not licensed by DPH must visibly post a statement approved by their Board of Directors incorporating DPH's statement of human rights. All hospitals that provide behavioral health inpatient services must have a human rights protocol that is consistent with DMH requirements (104 CMR 27.00), including a human rights officer and human rights committee.

INFORMING MEMBERS OF THEIR RIGHTS AND RESPONSIBILITIES

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

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

Beacon's *Member Rights and Responsibilities* is available in both English and Spanish from Beacon's website (www.beaconhealthoptions.com). You can also request a copy by calling Beacon at 888.204.5581 (TTY: 711).

4.3. Non-Discrimination Policy and Regulations

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

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

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

M.G.L. c. 151B, s. 4, cl. 10 prohibits discrimination against any individual who is a member of federal, state, or local public assistance, including medical assistance or unemployment compensation, solely because the individual is such a member. Accordingly, except as specifically permitted or required by regulations relative to institutional providers, no provider shall deny any medical service to a member eligible for such service unless the provider would at the same time and under similar circumstances, deny the same service to a person who is not a member of public assistance (e.g., no new members are being accepted, or the provider does not furnish the desired service to any member). A provider shall not specify a particular setting for the provision of services to a member who is not also specified for non- members in similar circumstances.

No provider shall engage in any practice, with respect to any health plan member, that constitutes unlawful discrimination under any other state or federal law or regulation, including but not limited to, practices that violate the provisions of 45 CMR Part 80 (relative to discrimination on account of race, color, or national origin), 45 CMR Part 84 (relative to discrimination against handicapped persons), and 45 CMR Part 90 (relative to age discrimination). In addition, providers shall not discriminate based on a member's income, physical or mental condition, age, gender, sexual orientation, religion, creed, color, physical or mental disability, national origin, English proficiency, ancestry, marital status, veteran's status, occupation, claims experience, duration of coverage, race/ethnicity, preexisting conditions, health status or ultimate payer for services.

Violations of the statutes and regulations set forth in the aforementioned paragraphs may result in administrative action, referral to the Massachusetts Commission Against Discrimination, or referral to the U.S. Department of Health and Human Services, or any combination of these.

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

4.4. Confidentiality of Member Information

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

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

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.

MEMBER CONSENT

At every intake and admission to treatment, providers should explain the purpose and benefits of communication to the member's PCP and other relevant providers. (See Chapter 5) The behavioral health clinician should then ask the member to sign a statement authorizing the clinician to share clinical status information with the PCP and for the PCP to respond with additional member status information. A sample form is available here (see Provider Tools web page), or providers may use their own form; the form must allow the member to limit the scope of information communicated.

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

CONFIDENTIALITY OF MEMBERS' HIV-RELATED INFORMATION

Beacon works in collaboration with the health plan to provide comprehensive health services to members with health conditions that are serious, complex, and involve both medical and behavioral health factors.

Beacon coordinates care with health plan medical and disease management programs and accepts referrals for behavioral health case management from the health plan.

Information regarding HIV infection, treatment protocols and standards, qualifications of HIV/AIDS treatment specialists, and HIV/AIDS services and resources, medications, counseling and testing is available directly from the health plan. Beacon will assist behavioral health providers or members interested in obtaining any of this information by referring them to the health plan's case management department. Beacon limits access to all health-related information, including HIV-related information and medical records, to staff trained in confidentiality and the proper management of patient information. Beacon's case management protocols require Beacon to provide any plan member with assessment and referral to an appropriate treatment source. It is Beacon's policy to follow federal and Commonwealth information laws and guidelines concerning the confidentiality of HIV-related information.

4.5. WellSense Health Plan Member Eligibility

WellSense Health PLAN MEMBER IDENTIFICATION CARDS

MassHealth Members

WellSense Health Plan MassHealth members are issued two cards—a health plan membership card and a MassHealth memberships card. Neither card is dated, nor are they returned when a member becomes ineligible. Therefore, the presence of a card does not ensure that a person is currently enrolled or eligible with the health plan.

A WellSense Health Plan MassHealth member card contains the following information:

- Member's name
- Health plan identification number
- Primary care provider
- Co-payment amount (if applicable)
- MassHealth ID or plan type

Senior Care Options (SCO) Members

WellSense Health Plan SCO members are issued one card—the health plan membership card.

Commercial Members

WellSense Health Plan Commercial members are issued one card—the health plan memberships card. A WellSense Health Plan Commercial member card contains the following information:

- Name

- Plan ID
- Co-payment amount

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

MEMBER ELIGIBILITY VERIFICATION

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

The following resources are available to assist in eligibility verification:

Member Eligibility Verification Tools

ONLINE	ELECTRONIC DATA INTERCHANGE (EDI)	VIA TELEPHONE
▪ Beacon's eServices--see Chapter 3 for more information ▪ MassHealth member Eligibility Verification System (EVS) - Providers will need a user name and password; go to www.mass.gov/masshealth/new to register.	▪ Providers with EDI capability can use the 270/271 EDI transaction with Beacon. To set up an EDI connection, view the companion guide then contact edi.operations@beaconhealthoptions.com.	▪ MassHealth AVR – 800.554.0042

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

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

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

Chapter 5

Quality Management and Improvement Program

5.1. Quality Management & Improvement Program Overview

On behalf of WellSense Health Plan, Beacon administers a Quality Management and Improvement (QM&I) program whose goal is to continually monitor and improve the quality and effectiveness of behavioral health services delivered to members. Beacon's QM&I Program integrates the principles of continuous quality improvement (CQI) throughout our organization and the provider network. These principles direct us to:

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

The goals and objectives of the Beacon QM&I program are to:

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

PROVIDER ROLE

Beacon employs a collaborative model of continuous quality management and improvement, in which provider and member participation is actively sought and encouraged. In signing the Provider Services Agreement, all providers agree to cooperate with Beacon and health plan QI initiatives. Beacon also requires each provider to have its own internal quality management and improvement program to continually assess quality of care, access to care and compliance with medical necessity criteria.

To participate in Beacon's Provider Stakeholder Committee, email provider.relations@beaconhealthoptions.com.

QUALITY MONITORING

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

- Site visits
- Treatment record reviews
- Satisfaction surveys
- Internal monitoring of timeliness and accuracy of claims payment
- Provider compliance with performance standards including, but not limited to timeliness of ambulatory follow-up after mental health hospitalization, discharge planning activities, communication with member PCPs, other behavioral health providers, government, and community agencies, tracking of adverse incidents, complaints, and grievances and appeals
- Other quality improvement activities

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

Documentation of events, incidents, and any complaints, grievances or appeals pertaining to each provider, is maintained and may be used by Beacon in profiling, recredentialing and network (re)procurement activities and decisions.

5.2. Treatment Records

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.

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.

5.3. Performance Standards and Measures

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

- 7- and 30-day ambulatory care rates; inpatient facilities are responsible for scheduling a follow up outpatient appointment within seven days of every member discharge
- 14-day medication monitoring
- Communication with PCPs and other providers treating shared members
- Availability of routine, urgent, and emergent appointments

Beacon Provider Quality Managers (PQMs) may work with providers to identify opportunities for improvement and develop Provider Quality Plans to be monitored on an ongoing basis.

5.4. Clinical Practice Guidelines

Beacon reviews and endorses clinical practice guidelines to support providers in making evidence based care treatment decisions on various topics. The most up-to-date, endorsed, clinical practice guidelines are posted on the Beacon website at https://www.beaconhealthoptions.com/providers/beacon/handbook/clinical-practice-guidelines/.

We strongly encourage providers to use these guidelines and to consider these guidelines whenever they may promote positive outcomes for clients. Additionally, each year, Beacon measures providers' adherence to at least three (3) Clinical Practice Guidelines or Resources. Beacon will review a portion of its members' medical records using the tool posted on the Beacon website. Questions have been developed from the guidelines/ resources.

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

5.5. Screening Program

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.

5.6 Outcomes Measurement

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

MassHealth requires a uniform behavioral health assessment process that includes a comprehensive needs assessment employing the Child and Adolescent Needs and Strengths (CANS) tool for all MassHealth members under age 21 receiving specific levels of care. The mandate to use the CANS tool is consistent with the Commonwealth's plan under the Children's Behavioral Health Initiative established in 2009, to more reliably identify the behavioral health needs of MassHealth members under age 21.

For MassHealth members over the age of 21, we require providers to utilize an outcomes tool to aid in guiding, assisting, and informing providers during the treatment process while facilitating communication between clients and their practitioners. While an outcomes tool is not required for Commercial members, we encourage its use. Please find a list of outcomes tools on Beacon's website at: www.beaconhealthoptions.com.

THE CHILD AND ADOLESCENT NEEDS AND STRENGTHS TOOL (CANS)

The CANS tool provides a standardized way to organize information gathered during the comprehensive clinical evaluation that is part of a behavioral health assessment. The CANS is intended to be used as a treatment decision support tool for behavioral health providers.

Behavioral health clinicians must be trained and certified in the use of CANS and recertification is required every two years. Questions about CANS training and certification should be directed to the CANS training group at mass.cans@umassmed.edu or 508.857.1116.

There are two forms of the Massachusetts CANS:

- "CANS Birth through Four" is used until a child's fifth birthday; and
- "CANS Five through Twenty" is used from the child's fifth birthday until the adolescent's 21st birthday.

The Massachusetts requirement to use CANS extends to all Beacon-contracted providers who provide behavioral health assessment and treatment to MassHealth members under age 21, for outpatient therapy, in-home therapy, in-home behavioral services, and intensive care coordination. Outpatient providers are required to use the CANS as part of an initial behavioral health assessment and must update it at least every 90 days. When a member is treated by more than one behavioral health provider, each provider is required to use the CANS. Inpatient providers are required to use CANS as part of the discharge planning process for 24-hour care, including:

- Psychiatric inpatient hospitalization
- Community-based acute treatment

Providers enter the CANS assessments via the EOHHS Virtual Gateway. All providers must have a Virtual Gateway account and a high-speed internet or satellite internet connection to access the CANS IT system.

Providers must obtain member consent to enter into the IT system the information gathered using the CANS tool and the provider's determination as to whether the assessed member is or is not suffering from a serious emotional disturbance (SED). If consent is not obtained, providers are still required to enter the SED determination.

5.7 Coordination and Continuity of Care

Beacon and WellSense Health Plan share a commitment to full integration of medical and behavioral health care services. Effective coordination improves the overall quality of both primary care and behavioral health services by:

- Supporting member access to needed medical and behavioral health services
- Reducing the occurrence of over- and under-utilization
- Increasing the early detection of medical and behavioral health problems
- Facilitating referrals for appropriate services

- Maintaining continuity of care

The health plan and Beacon require PCPs and behavioral health providers to coordinate care through ongoing communication directly related to their patient's health status. With informed member consent, behavioral health providers are required to provide PCPs with information related to behavioral health treatment needs and current treatment plans of shared members. If a member is receiving treatment from more than one provider, the guidelines in this section apply to all providers.

EDUCATE MEMBERS AND OBTAIN MEMBER CONSENT

Providers are expected to educate members about the benefits of care coordination and encourage them to grant consent for their clinical and environmental information to be shared among treatment providers. Notification requirements in this section can be fulfilled only with the member's consent. (See Chapter 4, Members and Member-Related Policies, for information about member consent.)

COMMUNICATION BETWEEN BEHAVIORAL HEALTH PROVIDERS AND PCPS, OTHER TREATMENT PROVIDERS

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

- Notice of commencement of outpatient treatment within four visits or two weeks, whichever occurs first
- Updates at least quarterly during the course of treatment
- Notice of initiation and any subsequent modification of psychotropic medications
- Notice of treatment termination within two weeks

Behavioral health providers may use Beacon's Authorization for Behavioral Health Provider and PCP to Share Information and the Behavioral Health-PCP Communication Form for initial communication and subsequent updates (both available on the Beacon website), or their own form that includes the following information:

- Presenting problem/reason for admission
- Date of admission
- Admitting diagnosis
- Preliminary treatment plan
- Currently prescribed medications
- Proposed discharge plan
- Behavioral health provider contact name and telephone number

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

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

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

COMMUNICATION BETWEEN INPATIENT/DIVERSIONARY PROVIDERS AND PCPS, OTHER TREATMENT PROVIDERS

With the member's informed consent, acute care facilities should contact the PCP by phone and/or by fax, within 24 hours of a member's admission to treatment. Inpatient and diversionary providers must also alert the PCP 24 hours prior to a pending discharge, and must fax or mail the following member information to the PCP within two days post-discharge:

- Date of discharge
- Diagnosis
- Medications
- Discharge plan
- Aftercare services for each type, including:
    - Name of provider;
    - Date of first appointment
    - Recommended frequency of appointments
    - Treatment plan

Inpatient and diversionary providers should make every effort to provide the same notifications and information to the member's outpatient therapist, if there is one.

Acute care providers' communication requirements are addressed during continued stay and discharge reviews and documented in Beacon's member record.

5.8 Transitioning Members from One Behavioral Health Provider to Another

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

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

5.9 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 by phone and by fax/electronic correspondence. Fax a copy of the completed Adverse Incident Report to 877.335.5452

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

5.10 Fraud and Abuse

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

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

Examples of Provider Fraud and Abuse: Altered medical records, patterns for billing, which include billing for services not provided, up-coding or bundling and unbundling or medically unnecessary care. This list is not inclusive of all examples of potential provider fraud.

Examples of Member Fraud and Abuse: Under/unreported income, household membership spouse/absent parent), out-of-state residence, third party liability, or narcotic use/sales/ distribution. This list is not inclusive of all examples of potential member fraud.

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

FEDERAL FALSE CLAIMS ACT

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

Summary of Provisions

The FCA imposes civil liability on any person who knowingly:

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

Penalties

The FCA imposes civil penalties and is not a criminal statute. Persons (including organizations and entities such as hospitals) may be fined a civil penalty of not less than $5,500 nor more than $11,000, plus triple

damages, except that double damages may be ordered if the person committing the violation furnished all known information within 30 days. The amount of damages in healthcare terms includes the amount paid for each false claim that is filed.

Qui Tam (Whistleblower) Provisions

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

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

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

Non-retaliation and Anti-discrimination

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

Reduced Penalties

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

If any member or provider becomes aware of any potential fraud by a member or provider, please contact us at 781.994.7500 and ask to speak to the Compliance Officer.

5.11 Complaints

Providers with complaints or concerns should contact Beacon at 866.444.5155 (TTY 711) and ask to speak with the clinical manager for the health plan. All provider complaints are thoroughly researched by Beacon and resolutions proposed within 20 business days.

If health plan members complain or express concerns regarding Beacon's procedures or services, health plan procedures, covered benefits or services, or any aspect of the member's care received from providers, they should be directed to call Beacon's Member Services department to file a complaint at 888.217.3501 (MassHealth members), 877.957.5600 (Commercial members) or TTY at 711.

5.12 Grievances and Appeal of Grievance Resolution

A Commercial or MassHealth member and/or the member's authorized member representative (acting on behalf of the member) may file a complaint/grievance with Beacon. Beacon reviews and provides a timely response and resolution of all delegated grievances that are submitted by members, authorized member representative (AMR), and/or providers. Every grievance is thoroughly investigated, and receives fair consideration and timely determination.

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

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

If the grievance is determined to be urgent, the resolution is communicated to the member and/or provider verbally within 24 hours, and then in writing within 30 calendar days of receipt of the grievance. If the grievance is determined to be non-urgent, Beacon's Complaints & Grievance Coordinator will notify the person who filed the grievance of the disposition of his/her grievance in writing, within 30 calendar days of receipt. For both urgent and non-urgent grievances, the resolution letter informs the member or member's representative to contact Beacon's Complaints & Grievance Coordinator in the event that he/she is dissatisfied with Beacon's resolution.

Member complaints and grievances for WellSense Health Plan Senior Care Options (SCO) are not delegated to Beacon. To file a member complaint/grievance for a SCO member, please call WellSense Health Plan at 855.833.8125.

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

Chapter 6

Utilization Management and Care Management

6.1. Utilization Management

Utilization Management (UM) is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning and retrospective review.

Beacon medical and clinical employees with responsibility for making UM decisions have been made aware that: All UM 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.

Financial incentives based on an individual UM clinician's number of adverse determinations or denials of payment are prohibited. Financial incentives for UM decision makers do not encourage decisions that result in under- utilization Note that the information in this chapter, including definitions, procedures, and determination and notification time frames may vary for different lines of business (MassHealth, Medicare and Commercial), based on differing regulatory requirements. Such differences are indicated where applicable.

MEDICAL NECESSITY

All requests for authorization are reviewed by Beacon clinicians based on the information provided. Beacon's medical necessity criteria are applied to determine appropriate care for all members.

Medically necessary services are services that are:

- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (most current version of ICD or DSM,) that threatens life, causes pain or suffering, or results in illness or infirmity.
- 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.
- No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
- Not a substitute for non-treatment services addressing environmental factors.

Additionally, the individual's needs and characteristics of the local service delivery system are taken into consideration.

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

Medical Necessity Criteria is available online via hyperlinks whenever possible and is available upon request.

UTILIZATION MANAGEMENT TERMS AND DEFINITIONS

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

UM Terms and Definitions

TERM	DEFINITION
Adverse Determination: Commercial Members	A decision to deny, terminate or modify (an approval of fewer days, units or another level of care other than was requested that the practitioner does not agree with) an admission, continued inpatient stay, or the availability of any other behavioral health care service(s) for: ▪ Failure to meet the requirements for coverage based on medical necessity ▪ appropriateness of health care setting and level-of-care effectiveness ▪ Health plan benefits.
Adverse Action: MassHealth Members	The following actions or inactions by Beacon or the provider organization: ▪ Beacon's denial, in whole or in part, of payment for a service failure to provide covered services in a timely manner in accordance with the waiting time standards ▪ Beacon's denial or limited authorization of a requested service, including the determination that a requested service is not a covered service ▪ Beacon's reduction, suspension, or termination of a previous authorization for a service ▪ Beacon's denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute adverse actions, including but not limited to, denials based on the following: • Failure to follow prior authorization procedures • Failure to follow referral rules • Failure to file a timely claim ▪ Beacon's failure to act within the time frames for making authorization decisions

TERM	DEFINITION
	▪ Beacon's failure to act within the time frames for making appeal decisions
Non-Urgent Concurrent Review and Decision	Any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments. A non-urgent concurrent decision may authorize or modify requested treatment over a period of time or a number of days or treatments, or deny requested treatment, in a non-acute treatment
Non-Urgent Pre-Service Review and Decision	setting Any case or service that must be approved before the member obtains care or services. A non-urgent pre-service decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment, in non-acute treatment setting.
Post-Service Review and Decision (formerly called "Retrospective Decision")	Any review for care or services that have already been received. A post-service decision would authorize, modify or deny payment for a completed course of treatment where a pre-service decision was not rendered, based on the information that would have been available at the time of a pre-service review.
Urgent Care Request and Decision	Any request for care or treatment for which application of the normal time period for a non-urgent care decision: ▪ Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment ▪ In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that could not be adequately managed without the care or treatment that is requested.
Urgent Concurrent Review Decision	Any review for a requested extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments in an acute treatment setting, when a member's condition meets the definition of urgent care, above
Urgent Pre-Service Decision	Formerly known as a precertification decision, any case or service that must be approved before a member obtains care or services in an inpatient setting, for a member whose condition meets the definition of urgent care above. An urgent pre-service decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment in an acute treatment setting

1. Emergency services do not require pre-service authorization; however, facilities must notify Beacon of the emergency treatment and/or admission within 24 hours (See Emergency Services later in this chapter)
2. Evaluation and Management services never require authorization. However, the initial evaluation by a psycho-pharmacologist (medication management) will require authorization. Extended visits for outpatient psycho-pharmacology or psychotherapy do require authorization.
3. Group therapy never requires authorization.
4. Out-of-network service is not a covered benefit. It may be authorized in some circumstances where needed care is not available within the network.
5...Detox and CSS providers are required to submit a notification of admission (NOA) through Beacon's eServices portal within 48 hours of admission. Up to 14 units will be covered prior to a clinical review per Massachusetts Chapter 258 of the Acts of 2014. For questions about how to access Beacon's eServices portal, see section 3.3 of this document or call Beacon.
6. Residential Rehabilitation Services (RRS) are a covered benefit for MassHealth members only. Providers submit a notice of admission (NOA) through Beacon's eServices portal. For questions about how to access Beacon's eServices portal, see section 3.3 of this document or call Beacon.

6.2. Authorization Procedures and Requirements

This section describes the processes for obtaining authorization for inpatient, diversionary and outpatient levels of care, and for Beacon's medical necessity determinations and notifications. In all cases, the treating provider, whether admitting facility or outpatient practitioner is responsible for following the procedures and requirements presented, in order to ensure payment for properly submitted claims. *Administrative denials may be rendered when applicable authorization procedures, including time frames, are not followed.*

MEMBER ELIGIBILITY VERIFICATION

The first step in seeking authorization is to determine the member's eligibility. Since member eligibility changes occur frequently, providers are advised to verify a health plan member's eligibility upon admission to, or initiation of, treatment as well as on each subsequent day or date of service to facilitate reimbursement for services. Instructions for verifying member eligibility are presented in Chapter 4. *Member eligibility can change, and possession of a health plan member identification card does not guarantee that the member is eligible for benefits. Providers are strongly encouraged to check Beacon's eServices or by calling Beacon at 866.444.5155.*

Auth orization Process by Level of Care	
Level of Care	**Process**
Inpatient Mental Health	Submit clinical on expedited auth website. Call assigned concurrent reviewer for Continued Stay requests.
CCS	Initial 5 days authorization exempt. Call NE Access Line for Continued Stay requests.
ICBAT/CBAT	Submit clinical on expedited auth website. Call assigned concurrent reviewer for Continued Stay requests.
TCU	Call assigned reviewer for Pre-certification and Continued Stay requests.
Partial Hospitalization Program (PHP)	Submit notice of admission on eServices for 12 units over 21 days. Designated providers must call NE Access Line for Precertification. Call assigned concurrent reviewer for Continued Stay requests.
Intensive Outpatient Program (IOP)	Initial 6 units over 14-day period is authorization exempt. Call concurrent reviewer for Continued Stay requests.

DDAT/EATS	Submit notice of admission (NOA) on eServices for initial 7 days. Call assigned concurrent reviewer for additional 7 days. *Note: Clinical review will not be conducted for the first 14 days of treatment per Massachusetts Chapter 258 of the Acts of 2014*
ATS (ASAM Level 3.7/Level 4.0)	Submit notice of admission (NOA) on eServices. Call assigned concurrent reviewer for additional 7 days. *Note: Clinical review will not be conducted for the first 14 days of treatment per Massachusetts Chapter 258 of the Acts of 2014*
CSS (ASAM Level 3.5)	Submit notice of admission (NOA) on eServices for 14 days. Call assigned concurrent reviewer for Continued Stay requests. *Note: Clinical review will not be conducted for the first 14 days of treatment per Massachusetts Chapter 258 of the Acts of 2014*
Residential Rehabilitation Services (RRS) Medicaid Only	Submit NOA on eServices for 90 units over 90 days. Complete concurrent review on eServices.
Structured Outpatient Addiction Program (SOAP)	Initial 20 units over 45 days authorization exempt. Call concurrent reviewer for Continued Stay requests.
Recovery Support Navigator (RSN)- Medicaid Only	Submit notice of admission (NOA) on eServices for 180 units over 90 days. Complete concurrent review on eServices for Continued Stay requests.
Recovery Coach (RC)Medicaid Only	Submit notice of admission (NOA) on eServices for 90 units over 90 days. Complete concurrent review on eServices for Continued Stay requests
rTMS	Complete rTMS request form and return via fax for both Precertification and continued stay requests.
Psych Testing and Neuropsych Testing	No authorization is required for outpatient Psych Testing and Neuro Psych Testing
ECT	For Inpatient ECT call assigned reviewer to complete precertification medical necessity review. No authorization is required for Outpatient ECT.
Community Support Program (CSP)	Obtain authorization on eServices. Complete concurrent review on eServices. Select providers are required to call assigned reviewer for continued stay review.
Routine Outpatient	Mental Health and substance use routine outpatient services do not require authorization.
Day Treatment	Complete Outpatient Review Form for Adult Day Treatment and return via eServices both pre-certification and continued stay review.
Family Support and Training (FS&T)	Call assigned reviewer to complete Pre-certification and Continued Stay review.
Intensive Care Coordination (ICC)	Medicaid: Submit Notice of Admission (NOA) via eServices, call assigned CBHI reviewer for Continued Stay requests. Commercial: Call assigned reviewer for Pre-certification and Continued Stay requests. Identified providers' authorization exempt.
In-Home Behavioral Services (IHBS)	Call assigned reviewer to complete Pre-certification and Continued Stay review.

Therapeutic Mentoring Services	Pre-certification and first Continued Stay review completed via the NOA on eServices. Call assigned CBHI reviewer for further Continued Stay requests.
In Home Therapy	Pre-certification and first Continued Stay review completed via the NOA on eServices. Call assigned CBHI reviewer for further Continued Stay requests.
Family Stabilization Team (FST)/In Home Therapy Commercial (IHT)	Call assigned reviewer to complete Pre-certification and Continued Stay review.

EMERGENCY SERVICES

Definition

Emergency services are those physician and outpatient hospital services, procedures, and treatments, including psychiatric stabilization and medical detoxification from drugs or alcohol, needed to evaluate or stabilize an emergency medical condition. The definition of an emergency medical condition follows: *"…a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person."*

Emergency care will not be denied; however, subsequent days do require pre-service authorization. The facility must notify Beacon as soon as possible and no later than 24 hours after an emergency admission and/or learning that the member is covered by WellSense Health Plan. If a provider fails to notify Beacon of an admission, Beacon may administratively deny any days that are not prior-authorized.

Emergency Screening and Evaluation

MassHealth mandates that Emergency Service Providers (ESPs) perform an emergency screening for all MassHealth enrollees requiring inpatient admission. If there are extenuating circumstances, and the ESP cannot evaluate the member in a timely manner (within one hour from telephone notification or member's arrival to the site), Beacon will allow a qualified clinician from a hospital emergency room or other evaluation site to provide the emergency evaluation for MassHealth members. This process allows members to access emergency services as quickly as possible and at the closest facility or by the closest crisis team. All ESPs are contracted providers for Beacon. After the emergency evaluation is completed, the ESP or facility clinician should call Beacon to complete a clinical review, if admission to a level of care that requires precertification is needed. The ESP is responsible for locating a bed, but may request Beacon's assistance. Beacon may contact an out-of-network facility in cases where there is not a timely or appropriate placement available within the network. In cases where there is no in-network or out-of-network psychiatric facility available, Beacon will authorize boarding the member on a medical unit until an appropriate placement becomes available. For Commercial and Medicare members, it is not mandated

that an ESP provide an evaluation for members requiring inpatient admission. However, an ESP may evaluate these members.

BEACON CLINICIAN AVAILABILITY

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

DISAGREEMENT BETWEEN BEACON AND ATTENDING PHYSICIAN

For acute services, in the event that Beacon's physician advisor (PA) and the emergency service physician do not agree on the service that the member requires, the emergency service physician's judgment shall prevail, and treatment shall be considered appropriate for an emergency medical condition, if such treatment is consistent with generally accepted principles of professional medical practice and is a covered benefit under the member's program of medical assistance or medical benefits. All Beacon clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention, triage and referral procedures.

INPATIENT AND DIVERSIONARY SERVICES INITIAL ASSESSMENT

Beacon requires a face-to-face evaluation for all members who require admission to acute services. To the maximum extent feasible, all members must be screened by a qualified behavioral health professional or at the nearest emergency room prior to admission to:

- Inpatient Mental Health
- Partial Hospitalization
- Intensive Outpatient Program
- Inpatient Substance Use Rehabilitation
- Inpatient Detoxification (Medically Managed and Medically Monitored)
- Crisis Stabilization Unit
- Ambulatory Detoxification

The purpose of this initial assessment is to determine whether a member meets level-of-care criteria for inpatient psychiatric treatment.

Pre-Service Review

Following the assessment and verification of the member's eligibility for health plan benefits, hospital clinical staff, or other providers wishing to provide or arrange for inpatient care, are required to call Beacon prior to admitting a covered health plan member to an inpatient unit on a non-emergency basis. The facility clinician making the request needs the following information for a pre-service review:

- Member's health plan Identification number
- Member's name, gender, date of birth, and city or town of residence
- Admitting facility name and date of admission
- DSM or appropriate ICD diagnosis (A provisional diagnosis is acceptable.)
- Description of precipitating event and current symptoms requiring inpatient psychiatric care
- Medication history
- Substance use history
- Prior hospitalizations and psychiatric treatment
- Member's and family's general medical and social history
- Recommended treatment plan relating to admitting symptoms and the member's anticipated response to treatment

Continued Stay (Concurrent) Review

Continuation beyond the previously authorized length of stay requires review and approval by Beacon prior to expiration of the existing authorization. To conduct a continued stay review, call a Beacon UR clinician with the following required information:

- Member's current diagnosis and treatment plan, including physician's orders, special procedures, and medications
- Description of the member's response to treatment since the last concurrent review
- Member's current mental status, discharge plan, and discharge criteria, including actions taken to implement the discharge plan
- Report of any medical care beyond routine is required for coordination of benefits with health plan (Routine medical care is included in the per diem rate.)

Member eligibility can change, and possession of a health plan member identification card does not guarantee that the member is eligible for benefits. Providers are strongly encouraged to check Beacon's eServices or by calling Beacon at 866.444.5155.

Notice of Inpatient/Diversionary Approval or Denial

Verbal notification of approval is provided at the time of pre-service or continuing stay review. For an admission, the evaluator then locates a bed in a network facility and communicates Beacon's approval to the admitting unit. Notice of admission or continued stay approval is mailed to the member or member's guardian and the requesting facility within the time frames specified later in this chapter.

If the clinical information available does not support the requested level of care, the UR clinician discusses alternative levels of care that match the member's presenting clinical symptomatology, with the requestor. If an alternative setting is agreed to by the requestor, the revised request is approved. If agreement cannot be reached between the Beacon UR clinician and the requestor, the UR clinician consults with a Beacon psychiatrist or psychologist advisor. All denial decisions are made by a Beacon physician or psychologist advisor. The UR clinician and/or Beacon physician advisor offers the treating provider the opportunity to seek reconsideration.

Members must be notified of all pre-service and concurrent denial decisions. Members are verbally notified by the provider of all acute pre-service and concurrent denial decisions. Members also receive a letter via mail. For members in inpatient settings, the denial letter is delivered by fax to the provider within one business day from the adverse determination decision. The service is continued without liability to the member until the member has been notified of the adverse determination.

The denial notification letter sent to the member or member's guardian, practitioner, and/or provider includes the specific reason for the denial decision, the member's presenting condition, diagnosis, and treatment interventions, the reason(s) why such information does not meet the medical necessity criteria, reference to the applicable benefit provision, guideline, protocol or criterion on which the denial decision was based, and specific alternative treatment option(s) offered by Beacon, if any. Based on state and/or federal statutes, an explanation of the member's appeal rights and the appeals process is enclosed with all denial letters.

All member notifications include instructions on how to access interpreter services; how to proceed if the notice requires translation or a copy in an alternate format; and toll-free telephone numbers for TDD/TTY capability, in established prevalent languages, (Babel Card). Notice of inpatient authorization is faxed to the admitting facility.

TRANSFER BETWEEN FACILITIES

Providers must request approval from Beacon prior to transferring members. The member must meet Beacon's admission criteria for the receiving facility prior to transfer. Without pre-service authorization for the receiving facility, elapsed days will not be reimbursed or considered for appeal.

OUTPATIENT SERVICES

Outpatient behavioral health treatment is an essential component of a comprehensive health care delivery system. All health plan members are covered for outpatient mental health and substance use services.

See Chapter 4 for more information about outpatient benefits, including co-payments Member benefits can also be found on eServices with other eligibility information.

Authorization Not Required for Initial Encounters (IEs)

As presented in Chapter 4:

- MassHealth, SCO and Commericial members do not require prior authorization for routine outpatient services

Other Exemptions from Authorization

- Group therapy (CPT code 90853) does not require authorization and does not count towards the member's IEs.
- Evaluation and Management services do not require authorization for all lines of business..
- Outpatient therapy services with a primary substance use disorder diagnosis do not require authorization.
- Office visits for medication-assisted treatment, such as Methadone Maintenance, Suboxone, and Vivitrol administration, do not require authorization.

Termination of Outpatient Care

Beacon requires that all outpatient providers set specific termination goals and discharge criteria for members. Providers are encouraged to use the level-of-care criteria to determine if the service meets medical necessity for continuing outpatient care.

Post-Service Review

Post-service reviews may be conducted for inpatient, diversionary or outpatient services rendered when necessary. To initiate a post-service review, call Beacon. If the treatment rendered meets criteria for a post- service review, the UR clinician will request clinical information from the provider, including documentation of presenting symptoms and treatment plan via the member's medical record. Beacon requires only those section(s) of the medical record needed to evaluate medical necessity and appropriateness of the admission, extension of stay, and the frequency or duration of service. A Beacon clinician completes a clinical review of all available information, in order to render a decision. *Authorization determination is based on the clinical information available at the time the care was provided to the member.*

DECISION AND NOTIFICATION TIME FRAMES

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

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

Please Note: Per the Commonwealth of Massachusetts, Executive Office of Health & Human Services contract with contracted Managed Care Organizations, based on 42 CFR Part 438, MassHealth members, member representatives or providers have the right to request an extension for up to 14 calendar days. The determination will be issued as expeditiously as the member's health requires but, no later than the date the extension expires.

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

Medicaid and Medicare Decision and Notification Time Frames

REQUEST	TYPE OF DECISION	DETERMINATION	VERBAL NOTIFICATION	WRITTEN NOTIFICATION
Pre- Service	Urgent	Within 72 hours from request	Within 72 hours from request	Within 72 hours from request
	Non-Urgent/ Standard	Within 14 Calendar Days	Within 14 Calendar Days	Within 14 Calendar Days
Concurrent Review	Urgent/ Expedited	Within 72 hours from request	Within 72 hours from request	Within 72 hours from request
	Non-Urgent/ Standard	Within 14 Calendar Days	Within 14 Calendar Days	Within 14 Calendar Days
Post- Service	Non-Urgent/ Standard	Within 30 calendar days	Within 30 calendar days	Within 30 calendar days

Commercial Decision and Notification Time Frames

REQUEST	TYPE OF DECISION	DETERMINATION	VERBAL NOTIFICATION	WRITTEN NOTIFICATION
Pre-Service	Urgent	Within 72 hours	Within 72 hours	Within 72 hours
	Non-Urgent/ Standard	Within 15 calendar days	Within 15 calendar days	Within 15 calendar days

	Urgent/ Expedited	Within 24 hours	Within 24 hours	Within 24 hours
Concurrent Review	Non-Urgent/ Standard	Within 15 calendar days	Within 15 calendar days	Within 15 calendar days
Post-Service	Non-Urgent/ Standard	Within 30 calendar days	Within 30 calendar days	Within 30 calendar days

6.3. Care Management

WellSense Health Plan's Behavioral Health Care Management Program for members with behavioral health and substance use needs is designed to ensure the coordination of care for members at significant clinical risk due to behavioral health conditions and psychosocial factors. The program includes assessment, care planning, advocacy and linkage to necessary supports and services.

Individualized care plans are developed in collaboration with members and their health care teams aimed at improving a member's overall functioning. BH Care management is provided by licensed behavioral health clinicians.

Referrals for WellSense Health Plan's BH Care Management Program are taken from inpatient facilities, outpatient providers, health plan representatives, PCPs, state agencies, members and their families.

Screening criteria for the care management program may include, but are not limited to, the following:

- Member has a prior history of acute psychiatric or substance use disorder admissions authorized by Beacon, with a readmission within a 60-day period
- First inpatient hospitalization following serous suicide attempt or treatment for first psychotic episode
- Member has combination of severe, persistent psychiatric clinical symptoms and lack of family or social support along with an inadequate outpatient treatment relationship which places the member at risk of requiring acute behavioral health services
- Presence of a co-morbid medical condition that when combined with psychiatric and/or substance use issues could result in exacerbation of fragile medical status
- Adolescent or adult who is currently pregnant, or within a 90-day postpartum period who is actively using substances, or requires acute behavioral health treatment services
- Other, complex, extenuating circumstances where the BH Care Managment team determines the benefit of inclusion beyond standard criteria

Intensity of care management staff involvement is dictated by how members were referred to the program, individual member needs and the member's choice for involvement with the program. Members who may be in need of more intensive services based on screening of needs are generally presenting with significant behavioral health symptoms including chronic mental illness, substance use, and medical co-morbid conditions. These members exhibit a combination of barriers and risk factors, including psychosocial stressors, multiple acute treatment episodes, fragmented outpatient care, and/or difficulties with access to care that result in a lack of follow through and participation in treatment leading to medication and treatment non-adherence, severe symptoms and treatment failures. WellSense Health Plan's BH Care Management model emphasizes recovery and resiliency and reinforces a collaborative approach among members, families, providers and community-based supports. Care managers will also emphasize employment, social and other natural supports, and methods of self-determination, as appropriate.

Members who are referred for episodic support or who have been referred for care management services but who choose to not be actively enrolled in the program can still take advantage of the benefits of staff expertise and support but may not require the completion of a full care management assessment. WellSense Health Plan's BH Care Management is a voluntary program, and member consent is required for participation. Beacon can transfer a provider to BMCHP BH Care Management staff for information on how to refer a member to case management services. Please call Beacon at 866.444.5155.

Chapter 7

Clinical Reconsideration and Appeals

7.1. Request for Reconsideration of Adverse Determination

If a member or member's provider disagrees with a utilization review decision issued by Beacon, the member, his/her authorized representative, or the provider may request reconsideration. Please call Beacon promptly upon receiving notice of the denial for which reconsideration is requested.

A peer review conversation may be requested at any time by the treating provider, and may occur prior to or after an adverse determination, upon request for a reconsideration. Beacon UR clinicians and physician advisors (PAs) are available daily to discuss denial cases by phone at 866.444.5155.

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

7.2. Clinical Appeal Processes

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

Appeal policies are made available to members and/or their appeal representatives as enclosures in all denial letters, and upon request. Every appeal receives fair consideration and timely determination by a Beacon employee who is a qualified professional. Beacon conducts a thorough investigation of the circumstances and determination being appealed, including fair consideration of all available documents, records, and other information without regard to whether such information was submitted or considered in the initial determination. Punitive action is never taken against a provider who requests an appeal or who supports a member's request for an appeal. Member appeals and grievances for WellSense Health Plan Senior Care Options (SCO) are not delegated to Beacon. To appeal an adverse action/adverse determination for a SCO member, please call WellSense Health Plan at 855.833.8125.

PEER REVIEW

For all acute and diversionary levels of care, adverse determinations are rendered by board-eligible or board-certified psychiatrists of the same or similar specialty as the services being denied. A peer review conversation may also be requested at any time by the treating provider, and it may occur prior to an adverse determination or after, upon request for a reconsideration.

URGENCY OF APPEAL PROCESSING

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

DESIGNATION OF AUTHORIZED MEMBER REPRESENTATIVE (AMR)

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

APPEAL PROCESS DETAIL

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

1. Expedited Clinical Appeals

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

EXPEDITED CLINICAL APPEALS
MASSHEALTH

LEVEL 1 APPEAL	LEVEL 2 APPEAL	EXTERNAL REVIEW
Members, their legal guardian, or their AMR have up to 30 calendar days after receiving notice of an adverse action in which to file an appeal. If the member designates an AMR to act on his/ her behalf, Beacon will attempt to obtain a signed and dated Designation of Appeal Representative Form. Every attempt will be made to have this form completed prior to the deadline for resolving the appeal. All expedited internal appeals will be processed by Beacon even if we have not received the Designation of Appeal Representative Form. The provider may act as the member's AMR. However, the provider must still submit a signed authorized Designation of Appeal Representative Form (AMR) to Beacon as documentation that the member did in fact authorize the provider to file an expedited internal appeal on the member's behalf. However, Beacon may not delay or dismiss an expedited appeal if the signed form is not submitted. A Beacon Physician Advisor, who has not been involved in initial decision, reviews all available information and attempts to speak with the member's attending physician. A decision is made within 72 hours of the initial request. Throughout the course of an appeal, the member shall continue to receive services for concurrent review denials only, without liability for services previously authorized by Beacon, until he/she is notified of the appeal determination.	N/A	Members, their legal guardian, or AMRs who remain aggrieved by an expedited internal appeal decision, have the option to request an external review from the Executive Office of Health and Human Services, Office of Medicaid's Board of Hearings (BOH). Beacon will provide the BOH with all documentation relating to the expedited internal appeal. Members or their AMR must make this request to BOH within 20 days after the expedited internal appeal decision, but within 10 days if they wish to receive continuing services without liability. Members or their AMR must complete the Request for Fair Hearing Form, included with the expedited internal appeal decision notification and submit to BOH. **Contact Information** Members or their AMR should contact the Beacon Appeals Coordinator for assistance in making the request to BOH at 800.414.2820.

	N/A	Members, their legal guardian, or AMRs who remain aggrieved by an expedited internal appeal decision have the option to request an external review from an external review agency (ERA) up to 180 days to file an appeal after notification of Beacon's adverse determination with the
The provider must still submit a signed authorized Designation of Appeal Representative Form (AMR) to Beacon as documentation that the member did in fact authorize the provider to file an expedited internal appeal on the member's behalf. However, Beacon may not delay or dismiss an expedited appeal if the signed form is not submitted. A Beacon physician advisor, who has not been involved in initial decision, reviews all available information and attempts to speak with the member's attending physician. A decision is made within 72 hours of the initial request. Throughout the course of an appeal for services previously authorized by Beacon, the member shall continue to receive services for concurrent review denials only, without liability until notification of the appeal resolution, provided the appeal is filed on a timely basis. **Contact Information** Appeal requests can be made by calling Beacon's Appeals Coordinator at 800.414.2820. WellSense Health Plan, in lieu of Beacon, may review the appeal request at the member or AMR's request.		Department of Public Health Office of Patient Protection (OPP). Beacon will provide the ERA with all documentation relating to the expedited internal appeal. Members or their AMR must make this request to OPP within 4 months after the expedited internal appeal decision, but within two days if they wish to receive continuing services without liability. **Contact Information** Members or their AMR should contact the Beacon Appeals Coordinator for assistance in making the request to the Office of Patient Protection (OPP) at 800.414.2820. Members or their AMR may also contact OPP directly. Call 800.436.7757 or go to **http://www.mass.gov/hpc/opp** to obtain the forms and additional instructions or the external review. (There is a fee of $25.)

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

Standard Clinical Appeals – MassHealth and Commercial

STANDARD CLINICAL APPEALS MASSHEALTH		
LEVEL 1 APPEAL	**LEVEL 2 APPEAL**	**EXTERNAL REVIEW**
Members, their legal guardian, or their AMR have up to 30 calendar days after receiving notice of an adverse action to file an appeal. When the member is designating an appeal representative to appeal on his/her behalf, the member must complete and return a signed and dated Designation of Appeal Representative Form prior to the deadline for resolving the appeal (30 calendar days). The Designation of Appeal Form is required even if the provider is acting as the authorized representative. Failure to do so prior to the appeal due date will result in dismissal of the appeal. However, verbal and written communication can only occur with the member or their legal guardian until such time as the form is received. If an individual other than the member or their legal guardian requests the standard first level appeal, the member must complete and return the Designation of Appeal Representative Form prior to the deadline for resolving the appeal. Failure to do so will result in the dismissal of the appeal and notice of dismissal to the member only. A Beacon physician advisor, not involved in the initial decision, will review available information and attempt to contact the member's attending physician/provider. Resolution and notification will be provided within 20 calendar days of the appeal request. If the appeal requires review of medical records (post service situations), the member or AMR's signature is required on an Authorization to Release Medical Information Form authorizing the release of medical and treatment information relevant to the appeal.	N/A	MassHealth members or their AMR should contact Beacon's appeals coordinator for help for external appeal with BOH. Beacon will provide BOH with all documentation relating to the standard first and/or second level appeal. MassHealth members or their AMR must submit requests to BOH within 30 days from Beacon's standard first or second level appeal decision notification, but within 10 days if they wish to receive continuing services without liability. Members may be held liable to pay back MassHealth for continuing services if the appeal is not resolved in their favor. MassHealth members or their AMR must complete the Request for Fair Hearing Form included with all levels of appeal decisions, and submit to BOH. An external review agency with review case if the member is not satisfied with the second level hearing. **Contact Information** Appeal requests can be made by calling Beacon's Appeals Coordinator at 800.414.2820 or in writing: Appeals Coordinator Beacon Health Strategies 500 Unicorn Park Drive Suite 401 Woburn, MA 01801

Mass Health members must submit an appeal request within 10 days of the adverse action in order to continue services without liability. The provider must submit the medical chart for review. If the chart is not received within 20 days of the initial letter, a reminder letter is sent, giving an additional 15 days. If the chart is not received, a decision is made based on available information. **Contact Information** Appeal requests can be made by calling Beacon's Appeals Coordinator at 800.414.2820 or in writing: Appeals Coordinator Beacon Health Strategies 500 Unicorn Park Drive Suite 103 Woburn, MA 01801 *WellSense Health Plan, in lieu of Beacon, may review the appeal request at the member or AMR's Request.		Or Board of Hearings Office of Medicail 100 Hancock Street, 6th Floor Quincy, MA 02171 800.655.0338 or 617.847.1200 Fax: 617.847.1204

A Beacon physician advisor not involved in the initial decision, will review available information and attempt to contact the member's attending physician/provider. Resolution and notification will be provided within 30 calendar days of the appeal request. If the appeal requires review of medical records (post- service situations), the member's or AMR's signature is required on an Authorization to Release Medical Information Form authorizing the release of medical and treatment information relevant to the appeal. The Designation of Appeal Form is required even if the provider is acting as the authorized representative. If the medical record with Authorization to Release Medical Information Form is not received prior to the deadline for resolving the appeal, a resolution will be rendered based on the information available. **Contact Information** Appeal requests can be made by calling Beacon's Appeals Coordinator at 800.414.2820 or in writing: Appeals Coordinator Beacon Health Strategies 500 Unicorn Park Drive Suite 103 Woburn, MA 01801		Commercial members or their AMR must file a request in writing with the OPP within four months of Beacon's first level appeal Adverse Determination. Any requests seeking continuation of coverage during appeal review must be received by OPP within two business days of receipt of Beacon's first level appeal adverse determination. **Contact Information** Members or their AMR should contact the Beacon Appeals Coordinator for assistance in making the request to OPP at 800.414.2820; however, members or their AMRs may contact the Office of Patient Protection (OPP) directly at 800.436.7757or **http://www.mass.gov/hpc/opp** to obtain the forms and additional instructions for the external review. (There is a fee of $25, which is paid by Beacon.)

*WellSense Health Plan, in lieu of Beacon, may review the appeal request at the member or AMR's request.

7.3. Administrative Appeal Processes

A provider may submit an administrative appeal, when Beacon denies payment based on the provider's failure to following administrative procedures for authorization. (Note that the provider may not bill the member for any services denied on this basis.)

Providers must submit their appeal concerning administrative operations to the Beacon ombudsperson or appeals coordinator no later than 60 days from the date of their receipt of the administrative denial decision. The ombudsperson or appeals coordinator instructs the provider to submit in writing the nature of the administrative appeal and documentation to support an overturn of Beacon's initial decision. The following information describes the process for first and second level administrative appeals:

- **First Level** administrative appeals for both commercial and Medicaid members should be submitted in writing to the appeals coordinator at Beacon. Provide any supporting documents that may be useful in making a decision. (Do not submit medical records or any clinical information.) An administrative appeals committee reviews the appeal, and a decision is made within 30 calendar days of date of receipt of appeal. A written notification is sent within two business days of the appeal determination.
- **Second Level** administrative appeals for both commercial and Medicaid members should be submitted in writing to the president at Beacon. A decision is made within 30 calendar days of receipt of appeal information, and notification of decision is sent within two business days of appeal determination.

Chapter 8

Billing Transactions

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

8.1. General Claims Policies

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

- The required edits, minimum submission standards, signature certification form, authorizing agreement and certification form, and data specifications as outlined in this Manual must be fulfilled and maintained by all providers and billing agencies submitting EDI to Beacon.
- The individual provider is ultimately responsible for accuracy and valid reporting of all claims submitted for payment. A provider using the services of a billing agency must ensure through legal contract (a copy of which must be made available to Beacon upon request) the responsibility of a billing service to report claim information as directed by the provider in compliance with all policies stated by Beacon.
- All information supplied by Beacon or collected internally within the computing and accounting systems of a provider or billing agency (e.g., member files or statistical data) can be used only by the provider in the accurate accounting of claims containing or referencing that information. Any redistributed or dissemination of that information by the provider for any purpose other than the accurate accounting of behavioral health claims is considered an illegal use of confidential information.
- At any time, Beacon can return, reject, or disallow any claim, group of claims, or submission received pending correction or explanation.
- Providers are not permitted to bill health plan members under any circumstances for covered services rendered, excluding co-payments when appropriate. See Chapter 3, Prohibition on Billing Members, for more information

TIME LIMIT FOR FILING CLAIMS

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

Plan	Benefit	Filing Limit
WellSense	**Masshealth**	▪ Within 150 days of the dates of service on outpatient claims ▪ Within 150 days of the date of discharge on inpatient claims ▪ Within 150 days from the last date on an interim bill on an inpatient claim.
WellSense	**QHP**	▪ Within 90 days of the dates of service on outpatient claims ▪ Within 90 days of the date of discharge on inpatient claims ▪ Within 90 days from the last date on an interim bill on an inpatient claim.

WellSense SCO		▪ Within 150 days of the dates of service on outpatient claims ▪ Within 150 days of the date of discharge on inpatient claims ▪ Within 150 days from the last date on an interim bill on an inpatient claim.

Providers are encouraged to submit claims as soon as possible for prompt adjudication. Claims submitted after the filing limit will deny unless submitted with a valid and approved Waiver Request Form (Waiver Policy later in this chapter).

All clean claims will be adjudicated within 30 days from the date that Beacon receives the claim.

Definition of Clean Claims

A clean claim, as discussed in this Manual, the Provider Services Agreement, and in other Beacon informational materials, is defined as one that has no defect or is not missing any required substantiating documentation of particular circumstance requiring special treatment that prevents timely payments from being made on the claim.

Clean claims may be submitted electronically, through EDI or eServices as described in the following sections. While paper claims are discouraged, instructions for submitting on paper are also included in this chapter.

CLAIMS INQUIRIES

- **eServices**
  Providers can check claim status 24/7 via eServices, regardless of how claims were submitted.
- **Claims Hotline: 888.249.0478**
  Hours of operation are Monday through Friday from 8:30 a.m. to 5:30 p.m.

8.2. Submission of Claims

ELECTRONIC SUBMISSION OF CLAIMS

Beacon strongly encourages providers to rely on electronic submission in order to realize the following advantages:

- Expedited processing, allowing providers to view claim status within hours of submission
- Increased accuracy of submissions, increasing approval rates for providers
- Automated tracking and better control flow
- Reduction in errors that lead to resubmission

- Improved reporting

Beacon offers two electronic methods for submitting claims, EDI and eServices, described below.

1. Electronic Data Interchange (EDI)

EDI supports electronic submission of claim batches in HIPAA-compliant 837P format for professional services and 837I format for institutional services, through Electronic Data Interchange (EDI). Providers may submit claims using the EDI/837 format directly to Beacon or through a billing intermediary.

Note: If using Emdeon as the billing intermediary, the following IDs must be included in the 837 file for adjudication:

Beacon's payor ID is 43324.

Beacon's WellSense Health Plan ID is 20.

Beacon's WellSense Health Plan Senior Care Options (SCO) Plan ID is 161.

Beacon requires testing for all submitters, including providers and/or their billing intermediaries, prior to submission of 837P and 837I transactions. After testing is successfully completed, providers and/or their billing intermediaries submit 837 claim transaction files by direct internet connection via one of the following options:

- Batch upload through ProviderConnect
- Batch upload through FileConnect
- Batch upload via SFTP

When the claims in the 837 file are adjudicated, the explanation of benefits (EOB) remittance report can be downloaded from Payspan, Beacon's EFT vendor, in the HIPAA 835 transaction format. Claim status is also available through eServices; claim status is also accessible telephonically through Beacon's IVR.

Providers interested in submitting EDI claims using the HIPAA-compliant 837 transaction, should download and review the 837 companion guide, then email Beacon at esupport.services@beaconhealthoptions.com for set-up and testing. Additional EDI resources are available at on our website.

All submitters must adhere to the following Beacon Electronic Submission Policies:

1. Beacon will only accept files for processing that meet the file format specifications as outlined in the HIPAA 837 Implementation Guide. The Beacon 837 Companion Guide supplements, but does not replace or contradict any requirements in, the Implementation Guide.
2. All requirements as outlined in the companion guide must be met.
3. An authorized representative of the provider, their agents or assignees may request documentation to ensure that all requirements are met.
4. Any applicable local, state, and/or federal regulatory agents may request actual information used to bill claims electronically. All information thus obtained will be held in confidence according to applicable local, state, and/or federal laws and regulations.

5. The provider for whom claims are submitted is ultimately responsible for the accuracy and validity of all such claims submitted for payment consideration. Any provider utilizing the services of a thirdparty entity to report claim information must be in compliance with all local, state, and/or federal policies and regulations. Both the provider and the third-party entity are required to maintain a record of all services submitted to Beacon for payment consideration

6. Any client/patient information collected by and held within the billing/accounting system of a provider or third-party entity must conform to all applicable local, state and federal confidentiality laws, policies and regulations.
7. Beacon retains the right to return, reject or disallow any claim, group of claims or claims files received via the Beacon system pending that claim, group of claims or claims files correction in compliance with the file format requirements as stated in the documents cited in Item 1 above.

8. A provider may utilize only one third-party entity per type of invoice for any period of time. Billing electronically through multiple billing agencies, clearinghouses or other third-party entities for the same invoice type is not permitted. EDI Helpdesk must be notified if a provider changes billing entities.

9. Billing agents, clearinghouses or other third-party entities are required to ensure that an Intermediary Authorization Form is on file for each provider contained in any files submitted by said agent.

2. eServices

eServices enables providers to submit inpatient and outpatient claims without completing a CMS 1500 or UB04 claim form; because much of the required information is available in Beacon's database, most claim submissions take less than one minute. For more information about using eServices, see Chapter 3 of this manual.

PAPER SUBMISSION OF CLAIMS

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

Beacon Health Options
WellSense Health Plan Claims Department
P.O. Box 1866
Hicksville, NY 11802-1866

Claim status is available in eServices regardless of how a claim was submitted.

Beacon Discourages Paper Transactions

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

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

Professional Services: Instructions for Completing the CMS 1500 Form

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

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

11c	No	Insurance Plan Name or Program Name (if applicable)
11d	No	Is there another health benefit plan?
12	Yes	Member's or Authorized Person's Signature and Date on File
13	No	Member's Authorized Signature
14	No	Date of Current Illness
15	No	Date of Same or Similar Illness
16	No	Date Client Unable to Work in Current Occupation
17	No	Name of Referring Physician or Other Source (if applicable)
17B	No	NPI of Referring Physician
18	No	Hospitalization dates Related to Current Services (if applicable)
19	Yes	Additional Claim Information (Designated by NUCC), if applicable. (Record ID if applicable)
20	No	Outside Lab?
21	Yes	Diagnosis or Nature of Illness or Injury.
22	No	Medicaid Resubmission Code or Former Control Number
23	Yes	Prior Authorization Number (if applicable)
24a	Yes	Date of Service
24b	Yes	Place of Service Code (HIPAA-compliant)
24d	Yes	Procedure Code (HIPAA-compliant between 290 and 319) and Modifier, when applicable

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

Note: Beacon requires the physician/practitioner's name and NPI number in box 24j.

All providers are required to record the name, site ID and address of the facility where services were rendered in Box 32 on the CMS 1500 claim form. If the facility name, site ID or address is not identified, a Beacon claim specialist will choose the 'primary' site as the default.

Institutional Services: Instructions for Completing the UB04 Form

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

TABLE BLOCK #	REQUIRED?	DESCRIPTION
1	Yes	Provider Name, Address, Telephone #
2	No	Untitled
3	No	Provider's Member Account Number
4	Yes	Type of Bill (3-digit codes)
5	Yes	Federal Tax ID Number
6	Yes	Statement Covers Period (include date of discharge)
7	Yes	Covered Days (do not include date of discharge)
8	Yes	Member Name
9	Yes	Member Address
10	Yes	Member Birthdate
11	Yes	Member Sex
12	Yes	Admission date
13	Yes	Admission Hour
14	Yes	Admission Type

15	Yes	Admission Source
16	Yes	Discharge Hour
17	Yes	Discharge Status
18-28	No	Condition Codes
29	No	ACDT States
30	No	Unassigned
31-34	No	Occurrence Code and Date
35-36	No	Occurrence Span
37	No	Untitled
38	No	Untitled
39-41	No	Value CD/AMT
42	Yes	Revenue Code (if applicable)
43	Yes	Revenue Description
44	Yes	Procedure Code (CPT) (Modifier may be placed here beside the HCPCS code)
45	Yes	Service Date
46	Yes	Units of Service
47	Yes	Total Charges
48	No	Non-Covered Charges
49	Yes	Modifier (if applicable)

50	No	Payer Name
51	Yes	Health Plan Identification Number
52	Yes	Release of Information Authorization Indicator
53	Yes	Assignment of Benefits Authorization Indicator
54	Yes	Prior Payments (if applicable)
55	No	Estimated Amount Due
56	Yes	Facility NPI
57	No	Other ID
58	No	Insured's Name
59	No	Member's Relationship to Insured
60	Yes	Member's Identification Number
61	No	Group Name
62	No	Insurance Group Number
63	Yes	Prior Authorization Number (if applicable)
64	Yes	RecID Number for Resubmitting a Claim
65	No	Employer Name
66	No	Employer Location
67	Yes	Principal Diagnosis Code
68	No	A-Q Other Diagnosis

69	Yes	Admit Diagnosis
70	No	Patient Reason Diagnosis
71	No	PPS Code
72	No	ECI
73	No	Unassigned
74	No	Principal Procedure
75	No	Unassigned
76	Yes	Attending Physician NPI/TPI – First and Last Name and NPI
77	No	Operating Physician NPI/TPT
78-79	No	Other NPI
80	No	Remarks
81	No	Code-Code

Note: Beacon requires the Attending NPI in box 76.

BILL TYPE CODES

All inpatient UB04 claims must include the three-digit bill type codes in Box 4.

DISCHARGE STATUS CODES

All inpatient UB04 claims must include one of the following discharge status codes in Box 17:

CODE	DESCRIPTION
01	Discharged to Home/Self-Care
02	Discharged/Transferred to Another Acute Hospital
03	Discharged/Transferred to Skilled Nursing Facility

04	Discharged/Transferred to Intermediate Care Facility
05	Discharged/Transferred to Another Facility
06	Discharged/Transferred to Home/Home Health Agency
07	Left Against Medical Advice or Discontinued Care
08	Discharged/Transferred Home/IV Therapy
09	Admitted as Inpatient to this Hospital
20	Expired
30	Still a Patient

Note: Beacon's contracted reimbursement for inpatient procedures reflect all-inclusive per diem rates.

INTERIM BILLING AND DATE RANGES

Beacon accepts interim billing on inpatient claims.

The date range on an interim bill must include the last day to be paid as well as the correct bill type and discharge status code. On an interim bill type X13, where X represents the "type of facility" variable, the last date of service included on the claim that will be paid is not considered the discharge day.

The date range on an inpatient claim that is not an interim bill must include the admission date through the discharge date. The discharge date is not a covered day of service but must be included as the "to" date. Refer to prior authorization letters for correct date ranges.

RESUBMISSION POLICY AND PROCEDURES

Claims that have previously denied may be resubmitted to Beacon in the following manner:

- If the original denied claim to be resubmitted was received by Beacon within the designated filing limit from the date of service[s], the corrected claim may be resubmitted as an original.
- If the original denied claim to be resubmitted was received by Beacon more than the designated filing limit from the date of service, the following procedures apply:
- *Note: The REC.ID corresponds with a single claim line on the Beacon EOB. Therefore, if a claim has multiple lines there will be multiple REC.ID numbers on the Beacon EOB.*

Electronic Resubmission

Denied claims can be resubmitted most efficiently by one of the following electronic methods:

- **EDI:** Follow the instructions in the EDI companion guide for correct placement of REC.ID number
- **eServices:** Claims can be automatically resubmitted by clicking “resubmit” next to the denied claim line in the search result screen. The REC.ID is auto-populated, and the user edits the data element that caused the denial. Claims can also be re-keyed; enter “yes” in the field indicating a resubmission/adjustment, then enter the REC.ID where indicated.

Paper Resubmission

When resubmitting a claim, Beacon requires that the REC. ID is submitted in box 64 on the UB04 claim form, or in box 19 or 22 on the CMS 1500 form. Only one REC. ID can be submitted per claim. When resubmitting a multiple line claim, Beacon requires each be resubmitted separately.

RESUBMISSION TIME FRAME

Resubmissions must be received by Beacon within the designated filing limit after the date on the EOB. A claim package postmarked on the 60th day is not valid.

Waiver Policy

Providers may request a waiver of the filing limit, when a claim being submitted for the first time will be received by Beacon after the original filing limit. To be approved, a waiver request must include evidence demonstrating that one or more of the following conditions has been met:

- Provider is retroactively eligible for reimbursement
- Member has been retroactively enrolled
- Third party coverage is available and was billed first (a copy of the other insurance’s explanation of benefits or payment is required)
- Member has been retroactively authorized for services

These conditions are the only valid reasons for submission of a waiver request. A Waiver Request Form that presents reasons not listed above will result in a claim denial on a future EOB. Claims that are outside of days but do not meet the above criteria should be submitted as a reconsideration request. To request a waiver:

- Complete a Waiver Form per the instructions below
- Attach any supporting documentation
- Prepare the claim as an original submission with all required elements ▪ Send the form, documentation and claim to:

Beacon Health Options
Claims Department/60-Day Waivers
P.O. Box 1866
Hicksville, NY 11802-1866

Completion of the Waiver Request Form

Providers are required to complete one Waiver Request Form per claim, as accurately and legibly as possible, including:

- **Provider Name**

  Enter the name of the provider who provided the service(s).
- **Provider ID Number**

  Enter the provider ID number of the provider who provided the service(s).
- **Member Name**

  Enter the member's name
- **Health Plan Member ID Number**

  Enter the WellSense Health Plan member ID number.
- **Contact Person**

  Enter the name of the person whom Beacon should contact if there are any questions regarding this request.
- **Telephone Number**

  Enter the telephone number of the contact person.
- **Reason for Waiver**

  Place an "X" on all the line(s) that describe why the waiver is requested.

- **Provider Signature**

  A waiver request cannot be processed without a typed, signed, stamped, or computer- generated signature. Beacon will not accept “Signature on file.”

- **Date**

  Indicate the date that the form was signed

Beacon’s Waiver Decision

Beacon’s determination regarding the waiver request is reflected on a future EOB: If the request is approved for waiver of the filing limit, the claim appears adjudicated; if the waiver request is denied, the reason for denial appears. Note that approval of a waiver request only means that the timely filing requirement has been overridden; approval does not guarantee payment of the associated claim. Each claim will pay or deny based upon normal adjudication logic.

Contact Beacon’s Member Services Department with any questions.

RECOUPMENTS AND ADJUSTMENTS BY BEACON

Beacon reserves the right to recoup money from providers due to errors in billing and/or payment. In that event, Beacon applies all recoupments and adjustments to future claims processed and reports such recoupments and adjustments on the EOB with Beacon’s record identification number (REC.ID) and the provider’s patient account number. ***Please do NOT send a refund check to Beacon***. **Provider Request for Adjustment or Void**

If the Explanation of Benefits (EOB) for a Beacon claim shows that a provider has been incorrectly paid, the provider must request an adjustment or void, as appropriate:

- **Adjustment** requests are filed to increase or decrease the original **amount paid** on a claim. Claims that have been denied cannot be adjusted but may be resubmitted. Adjustment requests can be filed electronically.
- **Void** requests are filed to refund the entire original payment on a claim, to Beacon. Void requests can only be sent via the paper adjustment process.

If an adjustment appears on an EOB and is not correct, another adjustment request may be submitted using the Beacon REC.ID from the previous adjustment.

Adjustment/void requests are not applicable for claims that have been denied. (See previous section on claim resubmission).

Underpayment (Positive Request)

Positive adjustment requests (when Beacon has underpaid the provider) must be submitted within 60 days from the date of payment as shown on the EOB.

Overpayment (Negative Request)

If an EOB shows that Beacon overpaid the provider on a single claim, the provider must submit an adjustment request to Beacon. The provider should not send a refund check. Beacon will investigate the need for an adjustment, and if a reduction in payment is warranted, Beacon will reduce the next payment to the provider, and this adjustment will be reflected in the provider's next EOB. If money is owed to Beacon, the filing limitation is not applicable.

Please do NOT send a refund check to Beacon.

Electronic Adjustment Requests

Adjustments to claims payments can be done electronically by submitting the paid claims with the REC.ID number via the following methods:

- **EDI:** Follow the instructions in the EDI companion guide for correct placement of REC.ID number.
- **eServices:** Claims can be automatically resubmitted through the claims search function by clicking "resubmit" next to the denied claim line in your search result screen. The system will automatically populate your REC.ID and will give you a chance to edit the data element that was causing the denial. Claims can also be re-entered, and the REC.ID can be manually entered after "yes" is entered in the resubmission/adjustment field.

Paper Adjustment Requests

When submitting an adjustment request, attach a copy of the original claim form and the EOB that reflects the payment to the adjustment form. Void requests must be submitted using the Adjustment/Void Request Form.

Adjustments to payment amounts can be done in one of the following manners:

- Complete the Adjustment/Void Request Form per the instructions below
- Attach copy of the EOB on which the claim was paid an incorrect amount
- Prepare the claim based on your requested final payment, with all required elements; place the REC.ID in box 19 of the CMS 1500 claim form, or box 64 of the UB04 form
- Send the form, documentation and claim to:

Beacon Health Options
Claims Department - 60-Day Waivers P.O. Box 1866
Hicksville, NY 11802-1866

Completion of the Adjustment/Void Request Form

To ensure proper resolution of your request, complete the Adjustment/Void Request form as accurately and legibly as possible. A copy of the original claim must be attached to the request.

- **Provider Name**

  Enter the name of the provider to whom the payment was made.

- **Provider ID Number**

  Enter the Beacon provider ID number of the provider that was paid for the service. If the claims was paid under an incorrect provider number, the claim must be voided and a new claim must be submitted with the correct provider ID number.

- **Member Name**

  Enter the member's name as it appears on the EOB. If the payment was made for the wrong member, the claim must be voided and a new claim must be submitted.

- **Health Plan Member ID Number**

  Enter the WellSense Health Plan member ID number as it appears on the EOB. If a payment was made for the wrong member, the claim must be voided and a new claim must be submitted.

- **Beacon Invoice Number**

  Enter the record ID number as listed on the EOB.

- **Beacon Paid Date**

  Enter the date the check was cut as listed on the EOB.

- **Check Appropriate Line**

  Place an "X" on all the line that describes the type of adjustment/void being requested.

- **Check All that Apply**

  Place an "X" on the line(s) that best describe the reason(s) for requesting the adjustment/void. If "Other" is marked, describe the reason for the request.

- **Provider Signature**

  An adjustment/void request cannot be processed without a typed, signed, stamped, or computer- generated signature. Beacon will not accept "Signature on file."

- **Date**

  Indicate the date that the form was signed

The provider must send Beacon the original adjustment/void request, along with a copy of the EOB on which the claim was paid. For an adjustment, include a copy of the newly adjusted claim form with the Adjustment/Void Request Form. Submit completed forms to:

Beacon Health Options
Claims Department – Adjustment Void/Request
P.O. Box 1866
Hicksville, NY 11802-1866

8.3. Reconsideration of Timely Filing Requests

In the event that a claim falls outside of all time frames for resubmission and adjustment described above, providers may request a reconsideration of the applicable filing limits. (See resubmission and adjustment sections in this chapter.)

To request reconsideration, submit the claim(s) to Beacon with a cover letter and all supporting documentation. The outcome of the reconsideration will be communicated as a message of “Reconsideration Approved” or “Reconsideration Denied” on your provider EOB.

Please note that in some circumstances it is possible to have determination of “Reconsideration Approved” that still results in a claim denial. The reconsideration process decides only if the timely filing limit will be overridden; all other billing/authorization requirements and adjudication logic still apply.

8.4. Coding

Providers are required to submit HIPAA-compliant coding on all electronic and paper claim submissions, including HIPAA-compliant revenue, CPT, HCPCS and ICD codes. Claims submitted without HIPAA- compliant coding will be denied for payment. Providers should refer to their exhibit A for a complete listing of contracted, reimbursable procedure codes.

MODIFIERS

Modifiers are used to make up specific code sets that are applied to identify services for correct payment. On the CMS 1500 claim form, place the modifier code in box 24d. On the UB04 claim form, place the modifier code in box 49 or beside the HCPCS code in box 44. The modifier reflects the discipline and licensure status of the treating practitioner. Please refer to your provider’s fee schedule for applicable modifiers.

MEDICATION MANAGEMENT

All providers must use the appropriate Evaluation and Management code when billing for a medication management session. In addition, one of the following modifiers is required to indicate the licensure level of the practitioner who provided the service:

- U6 - For licensed physician
- SA - For licensed RNCS

DIAGNOSIS CODES

Beacon accepts only International Classification of Diseases (ICD) diagnosis codes listing approved by CMS and HIPAA. Providers must record the appropriate primary diagnosis code in Box 21 on the CMS 1500 claim form and in Box 67 on the UB04 claim form. All diagnosis codes submitted on a claim form must be a complete diagnosis code with appropriate check digits.

8.5. Coordination of Benefits

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

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

- Beacon has TPL and COB specialists to address any specific questions regarding these types of claims. Providers should use the TPL Indicator Form to notify EOHHS of the potential existence of other health insurance coverage and to include a copy of the enrollee's health insurance card with the TPL Indicator Form whenever possible.

The TPL Indicator Form can be found on the Beacon web site at www.beaconhealthoptions.com, and see your Provider Tools page.

8.6. Provider Education and Outreach

In an effort to help providers that may be experiencing claims payment issues, Beacon runs quarterly reports identifying those providers that may benefit from outreach and education. Providers with low approval rates are contacted and offered support and documentation material to assist in reconciliation of any billing issues that are having an adverse financial impact and to ensure proper billing practices within Beacon's documented guidelines. Beacon's goal in this outreach program is to assist providers in as many ways as possible to receive payment in full, based upon contracted rates, for all services delivered to members.

How the Program Works

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

8.7. The Affordable Care Act Grace Period Information for Exchange Plans

GRACE PERIOD AND MEMBER CLAIMS

Under the Affordable Care Act, members who fail to pay their premiums have a grace period during which time members are considered eligible for benefits. If a claim is made during the grace period, insurers have the option to either pay or pend the claim, depending upon how late the premium payment is. The length of the grace period varies according to whether a member is with a subsidized on nonsubsidized plan. See below for more details.

Grace Periods for Members Receiving Advanced Premium Tax Credits – Subsidized Plans

The grace period for payment of premiums by those individuals who are receiving Advanced Premium Tax Credits and have paid at least one month's premium within the benefits year is three months. Beacon must pay claims for these individuals for the first month of a missed premium payment. After one month, and a premium payment is still delinquent for months two and three, plans have the option to either pend or pay the claim. If Beacon pends a claim, we must provide written notice to the provider that the claim is pended and may not be reimbursed if the

member does not pay the outstanding premium(s) within the grace period; we have the option to provide this notice electronically.

If a member pays the delinquent premium payment within the grace period, the member remains eligible for benefits, and Beacon will pay the pended claims. If not, the member's policy is canceled, and any pended claims will not be reimbursed. The provider may seek payment from the member in that case. Please note that providers are not allowed to balance bill members during months two and three of the grace period.

Examples

Here are examples the government provided to explain its regulation. Assumptions for a monthly premium:

- Premium: $500
- Advance premium tax credit share of premium: $450
- Enrollee share of premium: $50
- First month of grace period: March
- Patient pays enrollee share of premium for January and February coverage.

Example 1

Patient misses $50 payment due Feb. 28 for March coverage. Patient realizes mistake and pays $100 on March 31 for March and April coverage, satisfying all obligations for premium payments through the end of March.

- Insurer adjudicates claims for March consistent with normal practices (that is, for non-grace periods).
- Patient will have full coverage for March and April.

Example 2

Patient misses $50 payment due Feb. 28 for March coverage and misses $50 payment due March 31 for April coverage. Patient pays $150 on April 30 for March, April, and May coverage.

- Insurer adjudicates claims for March
- Coverage continues for April and May (second and third months of the grace period), but:
- Insurer notifies provider of the potential for a denied claim.
- Issuer pends claims for services performed in April and May until patient pays outstanding premiums.

Example 3

Patient misses $50 payment due Feb. 28 for March coverage; misses $50 payment due March 31 for April coverage; and misses $50 payment due April 30 for May coverage.

- Coverage is terminated retroactively to March 31.
- **Insurer can deny claims for services rendered during April and May**. Provider could then seek payment directly from the patient for any services provided during that time.

Grace Period for Members with a Non-Subsidized Plan

For those members who are NOT receiving Advanced Premium Tax Credits, the grace period for payment of premiums is 30 days. During this grace period, Beacon will pend the claims, and if the premium is paid in full within the 30-day grace period, Beacon will process the pended claims. However, if the member does not pay the premium within this time frame, the policy will be cancelled, and pended claims will be denied. As with members covered by subsidized plans, providers may seek payment for claims that have been denied due to nonpayment of premiums.

Important note: These grace periods make it even more important for providers to check member eligibility frequently. Possession of a health plan member identification card does not guarantee that the member is eligible for benefits. Providers are strongly encouraged to check Beacon eServices or by calling IVR at 888.210.2018.

Appendix A

Links to Forms

LINKS TO FORMS

The following forms are available on Beacon's website at www.beaconhealthoptions.com under Provider Tools:

- Adverse Incident Report Form
- Adjustment/Void Request Form (For Paid Claims Only)
- Authorization for Beacon Health Strategies to Release Confidential Information
- Authorization for Provider to Release Confidential Information to Beacon
- Authorization for Behavioral Health Provider and Primary Care Provider to Share Confidential Information
- Claim Inquiry Form
- CMS 1500 Standard Form
- Combined MCO Outpatient Review Form
- EDI Transactions - Billing Intermediary Authorization Form
- EDI Transactions - Trading Partner Set-up Form
- Family Stabilization Team Discharge Request
- Family Stabilization Team Extension Request
- Home-Based Therapy Appointment Form

- In-Home Therapy Extension Request Form
- In-Home Therapy Discharge Form
- Intensive Case Management - Initial Intake and Referral
- Primary Care Professional/Behavioral Health Communication Form
- Provider Directory Questionnaire
- Provider Credentialing Rights
- Psychological Testing Form
- Third Party Liability Indicator Form
- UB04 Form
- W-9
- Waiver Request Form