



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.



Beacon Health Options Provider Manual

NY Medicaid Addendum

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

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C h a p t e r 1

Overview of the Medicaid Program

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1.1. NY Medicaid Introduction

In 2011, Governor Andrew Cuomo established the Medicaid Redesign Team (MRT) that included workgroups charged to “conduct a fundamental restructuring of New York’s Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control, and a more efficient administrative structure.” Part of this effort included a multi-year roadmap for carving in certain fee-for-service (FFS) Medicaid benefits and populations, including behavioral health, into the State’s Medicaid Managed Care Program. The development of and transition of the services for adults over 21 started in 2015 for New York City and 2016 for the rest of New York State. This transition also included the development of specialized plans for adults with significant behavioral health needs called Health and Recovery Plans (HARPs).

Unlike the adult behavioral health transition to managed care where a new specialized product was developed for those with significant behavioral health needs, the children’s transition is more inclusive in scope. Supported by the MRT subcommittee recommendations, the State has envisions an integrated children’s health care system where there is “no wrong door” for children/youth experiencing complex needs, including children with complex medical or behavioral needs.

1.2. About the Children’s Program

NYS is collaborating with Medicaid Managed Care Organizations (MMCO) to manage the delivery of the expanded Medicaid-covered services for all Medicaid enrolled children. The goal is to fundamentally restructure and transform the health care delivery system for individuals under 21 that have behavioral health needs and/or medical complex conditions.

The goals of the NYS Medicaid redesign for children is to improve health outcomes, control Medicaid costs and provide care management for all Medicaid members that aligns incentives for the provision of high quality. A key feature of the model is to create a community based Medicaid managed care model where there is “no wrong door” for children/youth experiencing complex needs, including children with complex medical needs. NYS envisions a cross-system approach that diminishes silos of care and improves health outcomes for children well into adulthood.

Beacon Health Options (Beacon) is partnering with Health Plans to offer the behavioral health components of these programs.

To support integration and create better health outcomes for children and youth, NYS has taken the following key policy steps to stimulate the transformation:

- NYS will make available, via Medicaid, six new services that were previously not available or were only available to children who met narrow eligibility criteria.
- NYS is establishing level of care (LOC) and level of need (LON) criteria to identify subpopulations of children who are likely to benefit from an array of home- and community-based services (HCBS). The LON subpopulation will identify children prior to needing institutional care or as a step down from LOC. This population is at risk by virtue of exposure to adverse events or symptoms leading to functional impairments in their home, school or community. (Attachment A and Attachment B reflect eligibility criteria for LOC and LON resignations respectively).
- NYS is simplifying six existing children’s 1915(c) waivers into one integrated array of HCBS for an expanded number of Medicaid eligible children allowing them to stay in their home communities to avoid residential and inpatient care.

HEALTH HOME CARE MANAGEMENT FOR CHILDREN

Concurrent with managed care carve-in, children eligible for HCBS will be enrolled in Health Homes. The care coordination of service of the children's HCBS will transition to Health Home unless the child opts out of the Health Home. Health Homes will administer all HCBS assessments through the Uniform Assessment System which will have algorithms (except for the foster care developmentally disabled (DD) and OPWDD care at home medical fragile developmentally disabled (CAH MF) populations) to determine functional eligibility criteria for HCBS.

Via a phased approach, the following services will be managed under Medicaid managed care:

- Children's HCBS
- Outpatient addiction services
- Residential addiction services
- Licensed behavioral health practitioners
- Other Licensed Practitioner (OLP)
- Crisis Intervention
- Community Psychiatric Support and Treatment (CPST)
- Psychosocial Rehabilitation Services (PSR)
- Family Peer Support Services
- Youth peer support and training

To facilitate a smooth transition for children in receipt of HCBS, MMCOs will begin accepting POCs per the NYS Timeline for the following:

- a. MMCO enrolled population or a child for whom the Health Home Care Manager or Independent Entity has obtained consent to share the POC with the Plan and the family has indicated that the Plan selection process has been completed; and
- b. A child in the care of a LDSS/licensed VFCA, where Plan election has been confirmed. The Plan will continue to accept POC for children in receipt of HCBS in advance of the effective date of enrollment when the Plan is notified by another Plan, a Health Home Care Manager or the Independent Entity that there is consent to share the POC with the Plan and the family has demonstrated the Plan selection process has been completed, or for a child in the care of a LDSS/licensed VFCA, Plan selection has been confirmed by the LDSS/VFCA.

Transition of Children Placed in Foster Care and New York State Public Health Law Article 29-I Health Facility Services into Medicaid Managed Care

Effective July 1, 2021, children/youth placed in foster care, including those in direct placement foster care and placement in the care of VFCA statewide, will be mandatorily enrolled in MMC unless the child/youth is otherwise exempt or excluded from enrollment. In alignment with the MMC enrollment of the foster care population in the care of VFCA, VFCA may opt to become a licensed health care facility provider through New York State Public Health Law (PHL) Article 29-I, which provides for the provision of Core Limited Health-Related Services (CLHRS) and Other Limited Health-Related Services (OLHRS), and enter into agreements with Medicaid Managed Care Plans (MMCPs), including Mainstream Medicaid Managed Care and HIV Special Needs Plans, for the provision of these services to eligible enrolled children/youth. On July 1, 2021, CLHRS and OLHRS will be included in the MMCP Benefit Package.

Not all VFCA have elected to become Article 29-I providers; VFCA who opt out of Article 29-I licensure

are not authorized to provide health services and will not be reimbursed for Article 29-I health services through Medicaid FFS or MMC. However, children/youth placed in the care of these VFCAs and eligible for Medicaid will be enrolled in a MMCP unless otherwise exempted or excluded from enrollment.

Access to comprehensive, high quality health care is essential to children/youth placed in foster care. Children/youth in the foster care system have higher rates of birth defects, developmental delays, mental/behavioral health needs, and physical disabilities than children/youth from similar socio-economic backgrounds outside of the foster care system. Children/youth in foster care have a high prevalence of medical and developmental problems, and utilize inpatient and outpatient mental health services at a rate 15 – 20 times higher than the general pediatric Medicaid population. The impact of the trauma these children/youth experience is profound (Source: American Academy of Pediatrics). For this reason, it is essential that there be immediate access to services upon a child/youth's placement in foster care, and no interruption in the provision of ongoing services as a result of this transition.

I. Scope of Benefits Transitioning to Medicaid Managed Care

A. On July 1, 2021, MMCPs are responsible for providing all Benefit Package services to enrolled children/youth placed in foster care, promoting continuity of care, and ensuring health care services are delivered in a trauma-informed manner and consistent with standards of care recommended for children in foster care⁷. Children/youth often enter foster care without having had access to traditional preventive health care services. As a result, children/youth in foster care require an increase in the frequency of their health monitoring.

B. On July 1, 2021, MMCPs are responsible for covering the following 29-I Health Facility services for enrollees who are eligible to be served by a 29-I Health Facility, in accordance with the 29-I Billing Guidance:

1. Core Limited Health-Related Services (CLHRS) on a per diem basis, inclusive of:

- Nursing Services
- Skill Building Licensed Behavioral Health Practitioner (LBHP)
- Medicaid Treatment Planning and Discharge Planning
- Clinical Consultation/Supervision Services
- VFCA Managed Care Liaison/Administration

2. Medically necessary Other Limited Health-Related Services (OLHRS) that the 29-I Health Facility is authorized by the State to provide may include:

Children and Family Treatment Supports and Services (CFTSS)

- Other Licensed Practitioners (OLP)
- Community Psychiatric Supports and Treatment (CPST)
- Psychosocial Rehabilitation (PSR)
- Family Peer Supports and Services (FPSS)
- Youth Peer Support and Training (YPST)
- Crisis Intervention (CI)

Children's Waiver HCBS

- Caregiver Family Supports and Services
- Community Advocacy and Support
- Respite (Planned and Crisis)
- Prevocational Services
- Supported Employment
- Day Habilitation
- Community Habilitation
- Palliative Care: Bereavement Therapy
- Palliative Care: Expressive Therapy
- Palliative Care: Massage Therapy
- Palliative Care: Pain and Symptom Management
- Vehicle Modifications

- Adaptive and Assistive Equipment
- Non-Medical Transportation
- Environmental Modifications

3. Medicaid State Plan Services:

- i. Screening, diagnosis and treatment services related to physical health, including but not limited to:
 - Ongoing treatment of chronic conditions as specified in treatment plans
 - Diagnosis and treatment related to episodic care for minor ailments, illness or injuries, including sick visits
 - Primary pediatric/adolescent care
 - Immunizations in accordance with NYS or NYC recommended childhood immunization schedule
 - Reproductive health care
- ii. Screening, diagnosis and treatment services related to developmental and behavioral health. This includes the following:
 - Psychiatric consultation, assessment, and treatment
 - Psychotropic medication treatment
 - Developmental screening, testing, and treatment
 - Psychological screening, testing and treatment
 - Smoking/tobacco cessation treatment
 - Alcohol and/or drug screening and intervention
 - Laboratory tests

1.3. Quality Improvement Efforts Focused on Integrated Care

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

Beacon's strategies to promote behavioral health-medical integration for children, including at-risk populations, include:

- Provider access to rapid consultation from child and adolescent psychiatrists
- Provider access to education and training
- Provider access to referral and linkage support for child and adolescent patients

1.4. Behavioral Health Services

DEFINITION OF BEHAVIORAL HEALTH

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

ACCESSIBLE INTERVENTION AND TREATMENT

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

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

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

First Episode Psychosis

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

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

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

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

1.5. Covered Benefits and Services

BEHAVIORAL HEALTH BENEFITS FOR ALL MEDICAID POPULATIONS MANAGED UNDER 21

For effective dates for services, see the [NYS DOH Children's Medicaid Transformation Timeline](#)

- Assertive Community Treatment (ACT)- minimum age is 18 for medical necessity for this adult oriented service
- Community First Choice Option (CFCO) State Plan Services for Children meeting eligibility criteria
- Children's Day Treatment
- Comprehensive Psychiatric Emergency Program including Extended Observation Bed
- Continuing Day Treatment-minimum age is 18 for medical necessity for this adult oriented service
- Health Home Care Management
- Inpatient Psychiatric Services (OMH service)
- Licensed Behavioral Health Practitioner (LBHP) Service
- Licensed Outpatient Clinic Services (OMH services)
- Medically-Managed Detoxification (hospital-based) (OASAS service)
- Medically-Supervised Inpatient Detoxification (OASAS Service)
- Medically-Supervised Outpatient Withdrawal (OASAS services)
- OASAS Inpatient Rehabilitation Services
- OASAS Outpatient and Residential Addiction Services
- OASAS Outpatient Rehabilitation Programs
- OASAS Outpatient Services
- OMH State Operated Inpatient
- Other Licensed Practitioner (OLP)
- Partial Hospitalization
- Outpatient Clinic and Opioid Treatment Program (OTP) services (OASAS services)
- Partial Hospitalization
- Personalized Recovery Oriented Services (PROS)-minimum age is 18 for medical necessity for this adult oriented service
- Rehabilitation Services for residents of community residences
- Residential Rehabilitation Services for Youth (RRSY)

- Residential supports and services (Early Periodic Screening, Diagnostic and Treatment [EPSDT] Prevention, formerly known as foster care Medicaid Per Diem)
- Residential Treatment Facility (RTF)

ADDITIONAL SERVICES FOR CHILDREN MEETING TARGETING AND FUNCTIONAL NEEDS

For effective dates for services, see the [NYS DOH Children's Medicaid Transformation Timeline](#)

- Caregiver/Family Supports and Services
- Community Self-Advocacy Training and Support
- Children's State Plan Amendment Crisis Intervention Demonstration Services
- Community Psychiatric Support and Treatment (CPST)
- Family Peer Support Services
- Youth Peer Support and Training
- Habilitation (including habitative skill-building)
- Non-medical transportation
- Other Licensed Practitioner
- Peer Supports
- Planned Crisis
- Prevocationals Services
- Psychosocial Rehabilitation Supports
- Respite
- Supported Employment
- Teaching Family Home

A description of the new State Plan benefits may be found in the current [State Plan Services Manual](#). The HCBS benefits are listed below (additional detail can be found in the current [HCBS Manual](#)):

Children currently treatment at the time of benefit transition, may continue with their current care providers, including medical, behavioral health, and HCBS providers, for a continuous episode of care. Continuity of care will be in place for the first 24 months of the transition and it applies only to episodes of care that were ongoing during the transition period from fee-for-services to managed care.

1.6. Primary Care Provider Requirements for Behavioral Health

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

a. Deliver primary care services

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

1.7. Health Plan-Specific Contact Addendum

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

- Health plan EDI code
- Beacon hours of operation
- Beacon Ombudsperson phone number
- Beacon TTY number
- Interactive Voice Recognition (IVR)
- Beacon's Member Services phone number
- Beacon Claims Department address and phone number
- Beacon Clinical Appeals Coordinator phone number
- Plan/State required filing notice filing limit
- Beacon Provider Relations phone
- Time limits for filing inpatient and outpatient claims
- State Medicaid office address and phone
- State Fair Hearing Office address and phone
 - Number of days for fair hearing decisions
- State Independent Review Organization address and phone

Chapter 2

Children and Family Treatment Support Services (CFTSS) and Children HCBS Service Descriptions

Children and Family Treatment Support Services (CFTSS)

- 2.1. Other Licensed Practitioner
- 2.2. Crisis Intervention
- 2.3. Community Psychiatric Support & Treatment (CPST)
- 2.4. Psychosocial Rehabilitation
- 2.5. Family Peer Support Services
- 2.6. Youth Peer Support and Training

1915c Home and Community Based Services Review Guidelines and Criteria

- 2.7. Respite (Planned and Crisis)
- 2.8. Caregiver/Family Supports and Services
- 2.9. Prevocational Services
- 2.10. Supportive Employment
- 2.11. Community Self-Advocacy Training and Support
- 2.12. Day and Community Habilitation

Children and Family Treatment Support Services (CFTSS)

2.1. Other Licensed Practitioner

Non-physician licensed behavioral health practitioner (NP-LBHB) who is licensed in the State to prescribe, diagnose, and/or treat individuals with a physical, mental illness, substance use disorder, or functional limitations at issue, operating within the scope of practice defined in State law and in any setting permissible under State practice law (i.e., services can be delivered in the community outside the four walls of the agency). NP-LBHPs include individuals licensed and able to practice independently or are under the supervision or directions of a licensed clinical social worker, a licensed psychologist, or a psychiatrist. Activities would include:

- Recommending treatment that also considers trauma-informed, cultural variables, and nuances
- Developing recovery or treatment plan
- Activities within the scope of all applicable state laws and their professional license including counseling, individual, or family therapy
- Developing recovery oriented treatment plans

2.2. Crisis Intervention

Crisis intervention services are provided to all children/youth who are identified as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g. collateral, provider, community member) to effectively resolve it.

2.3. Community Psychiatric Support & Treatment (CPST)

Community Psychiatric Support & Treatment (CPST) services are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the child's treatment plan. CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings, but can benefit from community-based onsite rehabilitative services.

2.4. Psychosocial Rehabilitation

Psychosocial Rehabilitation Services (PRS) are designed to work with children and their families to implement interventions outlined on a treatment plan to compensate for or eliminate functional deficits and interpersonal and/or environment barriers associated with a child/youth's behavioral health needs.

2.5. Family Peer Support Services

Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical developmental,

substance use, and/or behavioral challenges in their home, school, placement, and/or community. FPSS provided a structure, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/ caregiver for the benefit of the child/ youth.

2.6. Youth Peer Support and Training

Youth Peer Support and Training (YPST) services are formal and informal services and supports provided to youth and families raising an adolescent who is experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community-centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process.

1915i Home- and Community-Based Services Review Guidelines and Criteria

Home- and Community-Based Services (HCBS) provide opportunities for Medicaid beneficiaries under 21 that have behavioral health needs and/or medically complex conditions to receive services in their own home or community. Implementation of HCBS will help to create an environment where managed care plans (Plans), Health Home Care Managers, CYES Case Managers (Independent Entity)service providers, plan members, and their chosen supporters/caregivers, and government partners help members prevent, manage, and ameliorate chronic health conditions and improve health outcomes.

All eligible members that consent will be linked to a local Health Home or CYES, if opting out of Health Home, for care coordination. Health Home care management is provided by the assigned community mental health agency The Plan, in partnership with the Health Home or CYES and HCBS providers, ensures medical and behavioral health care coordination and service provision for its members. The Plan will collaborate with Beacon to oversee and support CYES or Health Homes and HCBS providers via identified quality and utilization metrics and clinical review to ensure adherence with program specifications as defined by NYS-established criteria. The program oversight includes effectively partnering and engaging with contracted Health Home and HCBS providers to ensure that program operations and service delivery have a consistent focus on key factors that result in quality and efficacious treatment for eligible enrollees.

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

These review guidelines provide a framework for discussion between HCBS providers and Health Plans. The review process is a collaboration between all pertinent participants including but not limited to the Health Home Care Manager or CYES Care Manager HCBS provider, Plan, and member to review progress and identify barriers or challenges that may be interfering with a reasonable expectation of progress towards the members chosen goals. These conversations will focus on the member's needs, strengths, and history in determining the best and most appropriate fit of the services. These review guidelines are applied to determine appropriate care for all members. In general, services will be authorized if they meet the

specific criteria for a particular service. The individual's needs, choice, and characteristics of the local service delivery system and social supports are also taken into consideration.

Health Home Care Managers or CYES will determine eligibility for HCBS using a standard needs assessment tool. Procedures for authorizing specific HCBS include:

1. If the member is eligible for HCBS, the Health Home Care Manager or CYES Care Manager will complete an assessment that includes documentation of the member's needs, strengths, goals, and preferences.
2. In collaboration, the member and Health Home Care Manager or CYES Care Manager will develop a comprehensive and person-centered plan of care. The plan of care will reflect the member's assessed and self-reported needs, as well as those identified through claims review and case conference with providers when appropriate.
3. The Health Home Care Manager or CYES Care Manager will share results of the HCBS assessment and plan of care with the Plan for review and feedback.
4. If the member is enrolled with the Health Home, the Health Home will link the member with an HCBS provider. If the member is not enrolled with the Health Home, CYES or the Plan will link the member to the HCBS provider. Members will be offered a choice of HCBS providers from within the Plan's network.
5. HCBS provider(s) will conduct service specific assessment(s) and forward additional information to Health Home Care Manager or CYES Care Manager regarding intensity and duration of services. The Health Home Care Manager or CYES Care Manager will update the Plan with HCBS provider-specific information and present it to the MCO for review..
6. HCBS providers will be required to submit a notification to the Plan when a member has been accepted. The notification must be made before the member begins to receive HCBS. The HCBS and/or CMA provider will present the member's plan of care to the Plan for review. Notification will allow for authorization of specific HCBS interventions as well as collaborative monitoring to assure timely and appropriate care coordination. Plan utilization management will ensure the member's plan of care reflects the member's individual, assessed, and self-reported needs and is aligned with concurrent review protocols.

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

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

HEALTH HOMES AND HOME AND COMMUNITY BASED SERVICES (HCBS)

Beacon collaborates with the Plan's Health Homes and provides oversight of the HCBS plan of care process as it relates to behavioral health service integration. If member is not enrolled in Heath Home, Beacon collaborates with CYES for recertification of HCBS but maintains coordination of the Plan of Care for member. This collaboration includes, but is not limited to:

- Assurance of integrated and person-centered approaches to medical and behavioral health coordination of care via cross-discipline professional collaboration between the Health Homes,

HCBS providers, CYES and the Plan aimed at optimizing health outcomes for members

- Management of members with complex health needs, co-morbid conditions, and/or high-cost by ensuring timely communication between providers, exchange of treatment goals, plans of care, and progress information, in addition to encouraging innovation and creativity in joint problem solving
- Beacon and/or the Plan assigns internal clinical staff to liaise with the Health Home or CYES and HCBS service providers to support the plan of care process
- Assurance of completion of the comprehensive screening by the Health Home Care Coordinator or other qualified assessor to identify areas of need, short-term goals, and long- term goals. Screening includes identification of members who would benefit from HCBS services
- Assurance that assessment and subsequent plan of care includes unmet health needs, medication adherence, self-management skills and training, healthy living choices, and coordination of complex medical and behavioral care
- Assurance of annual re-evaluation of the plan of care (or re-evaluation due to change in status or adverse event) to measure the effectiveness of interventions in improving member outcome and quality of life as well as reducing adverse incidents or risk
- Analysis and data sharing with Health Homes regarding utilization data to identify trends of overuse in emergency department and inpatient admissions, while collaborating to develop a tailored strategy to reduce the number of inappropriate or unnecessary admits
- Beacon collaborates with our plan partners to work with providers to collect accurate baseline data. Provider profiles are shared with providers, Health Homes, and any other appropriate stakeholders in an effort to continuously improve clinical service delivery and health outcomes.
- In collaboration with the Plan, Beacon utilizes the level of care criteria sanctioned by NYS. Individual preferences and presence of functional impairment justify medical necessary criteria. Any resource allocation rules are followed by Beacon and the Plan.
- As appropriate, Beacon, in collaboration with the Plan, supports the State in building capacity in Health Homes by:
 - Utilizing standard reporting measures on cost and quality that tie behavioral health and medical financial, clinical, and member satisfaction outcomes together.
 - Completing network analyses in conjunction with the health plan to identify Health Homes and providers best suited for managing individuals with serious mental illness (SMI) or functionally limiting substance use disorders
- Beacon collaborates with the Plan to ensure that the NYS-established medical necessity criteria for each HCBS, as well as member's goals and preferences, will weigh into decisions made regarding services, but the regular medical necessity criteria will not apply (i.e., does not require active symptoms, the individual's preference and the presence of functional impairment is enough to support need when a medical order is not necessary).

HCBS services are only available to enrollees qualified through the assessment process and eligible individuals enrolled in HIV-SNPs and assessed as HCBS eligible. A mainstream plan may provide HCBS to its enrollees as a cost effective alternative to regular OMH and OASAS licensed/certified services (on an in lieu of basis and paid by the Mainstream plan from its capitation rate). In order to be reimbursable, services rendered, including scope and duration must be part of an approved personalized recovery plan.

For children transitioning from a 1915(c) waiver, the Plan must continue to authorize covered HCBS and LTSS in accordance with the most recent plan of care for at least 180 days following the date of transition of children's specialty services newly carved into managed care. Service frequency, scope, level, quantity, and existing providers at the time of the transition will remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with the plan) for no less than 180 days, during which time, a new plan of care is to be developed.

- a. During the initial 180 days of the transition, the Plan will authorize any children's specialty services newly carved into managed care that are added to the plan of care under a person-centered process without conducting utilization review.

2.7. Respite (Planned and Crisis)

Respite focuses on short-term assistance and/or relief for children with disabilities (developmental, physical and/or behavioral), and family/ caregivers which can be provided in a planned mode or delivered in a crisis environment. To the extent that the skilled nursing is provided as a form of respite, this service has to be ordered by a physician. This service may be provided in a one-to-one, individual session, or group session. The need for crisis respite may be identified as a result of a Medicaid State Plan crisis intervention or may come from referrals from the emergency room, the community, LDSS/LGU/SPOA, school, self-referrals, or as part of a step-down plan from an inpatient setting. Crisis respite should be included on the plan of care to the extent that it is an element of the crisis plan or risk mitigation strategy.

2.8. Caregiver/Family Supports and Services

These services are designed to enhance the child's ability, regardless of disability (developmental, physical, and/or behavioral), to function as part of a caregiver/family unit and enhance the caregiver/family's ability to care for the child in the home and/or community. Note: this service differs from the State Plan series of Family Peer Support Services, which is delivered by credentialed/certified Family Peer Specialist with lived experience.

2.9. Prevocational Services

Prevocational services are individually designed to prepare a youth age 14 or older to engage in paid work, volunteer work or career exploration. Prevocational services are structured around teaching concepts such as compliance, attendance, task completion, problem solving, and safety based on a specific curriculum related to youth with disabilities (developmental, physical, and/or behavioral). In addition, prevocational services assist facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements. Prevocational services are not job-specific, but rather are geared towards facilitating success in any work environment for children whose disabilities do not permit them access to other prevocational services. The service will be reflected in a participant's service plan directed to teaching skills rather than explicit employment objectives.

2.10. Supportive Employment

Supported employment services are individually designed to prepare individuals with disabilities (developmental, physical, and/or behavioral) age 14 and older to engage in paid work. Supported employment services provide assistance to participants with disabilities as they perform in a work setting. Supported employment provides ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in a competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but no less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

2.11. Community Self-Advocacy Training and Support

These services aim to improve the child's ability to gain from the community experience and enables the child's environment to respond appropriately to the child's disability and/or health care issues. The use of this service may appropriately be provided to prevent problems in community settings as well as when the child experiencing difficulty. The plan of care objectives must clearly state how the service can prevent as well as ameliorate existing problems and to what degree. This service cannot be used to develop an Individualized Education Program (IEP), the plan for students with disabilities who meet the federal and state requirements for special education, or to provide special education services to the child. This service may be provided in an individual session or in a group setting.

2.12. Habilitation

These services focus on helping children with developmental, medical, and behavioral disabilities who are eligible for HCBS to be successful in the home, community, and school by acquiring both social and environmental skills associated with his/her current developmental stage. This service assumes that the child has never had skills being acquire. Habilitation services assist children who have never acquired a particular skill with the self-help, socialization and adaptive skills necessary for successful functioning in the home and community when other types of skill-building services are not appropriate. This service may be delivered in an individual or group setting. Habilitation is provided to the child and the child's family/caregiver to support the development and maintenance of skill sets.

CRISIS RESIDENCE PROGRAMS

Crisis Residence Programs are licensed and regulated pursuant to OMH Part 589 regulations: [https://omh.ny.gov/omhweb/policy_and_regulations/adoption/adoption part 589.pdf](https://omh.ny.gov/omhweb/policy_and_regulations/adoption/adoption_part_589.pdf). The 3 OMH licensed Crisis Residence Programs are:

1. Children's Crisis Residences (Under 21)
2. Residential Crisis Support (18 and over)
3. Intensive Crisis Residence (18 and over)

Individuals aged 18-20 may receive services from a Children's Crisis Residence, a Residential Crisis Support or Intensive Crisis Residence Program. Individuals aged 18-20 are covered under the Children's State Plan Benefit. Individual and providers determine which program is most appropriate.

Children's Crisis Residence Program

Children's Crisis Residence Programs serve children under age 21. The length of stay anticipated of 21 days; maximum of 28 days, unless approved by MMCPs for enrollees. There is a maximum of 8 beds, no minimum. The program will ensure linkages and connections to community based services, medication management (if needed), and provide counseling related to the crisis situation that resulted in the admission. Wherever possible, children are expected to attend their school, continue the services they have received in the community and engage in new services (if needed) to prevent an escalation of symptoms. Children actively receiving services at a Crisis Residence may not receive duplicative behavioral health services in the community; however, they may begin or continue mental health services to ensure continuity of care or discharge planning goals. Treatment in the crisis residence will focus on the crisis situation which prompted admission to the program and be consistent with any crisis or mental health treatment plan already in effect for the child and their behavioral health needs.

Residential Crisis Support Program

The residential crisis support program provides voluntary, short term residential crisis support services to individuals experiencing a mental health crisis or challenges in daily life that create a risk for an escalation of symptoms that cannot be managed in the individual's home and community without onsite supports. Individuals do not need a diagnosis to receive or for MMCPs to reimburse for services. Individuals can receive Residential Crisis Support services for up to 28 days. Residential Crisis Support Programs have between 3-16 beds. Peer support is a critical component of this program. Adult BH HCBS Short term respite providers will be included in this category. Licensed Crisis Residence Programs will replace Adult BH HCBS crisis respite services. Provider licensure will be completed on a rolling and OMH is working to expedite the process. Active Adult BH HCBS short term crisis respite providers will be permitted to operate and be reimbursed for Residential Crisis Support Programs for adults 21 and over while completing the OMH licensing process.

Intensive Crisis Residence Program

A voluntary short term residential treatment service for individuals experiencing a mental health crisis to evaluate, resolve and/or stabilize crisis symptoms. There must be identified treatment needs. The program can address co occurring conditions. The individual must have a primary mental health diagnosis for reimbursement by Medicaid Managed Care. Individuals can receive Intensive Crisis Residence services

for up to 28 days. Intensive Crisis Residence Programs have between 3-16 beds and an interdisciplinary treatment team which includes Licensed Professionals, Para Professionals and NYS Certified Peers.

VOLUNTEER FOSTER CARE AGENCY PROGRAMS:

Extension of Children's services

Special Populations

Continuity of Care

Appointment Access and Availability for Assessments

Etc.

C h a p t e r 3

Provider Participation

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

3.1. Network Development and Network Operations

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

3.2. Contracting and Maintaining Network Participation

A "participating provider" is an individual practitioner, private group practice, licensed outpatient agency, New York State designated provider or facility that has been credentialed by and has signed a Provider Service Agreement (PSA) with Beacon. Participating providers agree to provide mental health and/or substance use disorder services and/ or HCBS to members; **have a procedure for monitoring utilization for each enrollee**; accept reimbursement directly from Beacon according to the rates set forth in the fee schedule attached to each provider's PSA; and adhere to all other terms in the PSA, including this provider manual. Note that for 24 months from the date of transition of the children's specialty services carve-in, for fee-for-service children in receipt of HCBS at the time of enrollment, the Plan must continue to authorize covered HCBS and LTSS in accordance with the most recent plan of care for at least 180 days following the effective date of enrollment. Service frequency, scope, level, quantity, and existing providers at the time of enrollment will remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with the plan) for no less than 180 days, during which time, a new plan of care is to be developed. While alternative payment arrangements, in lieu of the fee-for-service rates, may be allowed they require prior approval from OMH and OASAS.

The Plan must pay at least the Medicaid fee-for-service fee schedule for 24 months or as long as NYS mandates (whichever is longer) for the following services/providers:

- i. New EPSDT CFTSS services including OLP; Crisis Intervention; CPST; PSR; Family Peer Support Services and Youth Peer Support and Training; and Preventive Residential Supports
- ii. OASAS clinics (Article 32 certified programs)
- iii. All OMH Licensed Ambulatory Programs (Article 31 licensed programs)
- iv. Hospital-based and free-standing clinics dually (Article 28 licensed and/or certified programs)

Providers who historically delivered care management services under one of the 1915(c) waivers being eliminated, and who will provide care management services that are being transitioned to Health Home, may receive a transitional rate for no more than 24 months. The transitional rates will be as financially equivalent as practical to the interim rates (and as reconciled) established under the former waivers and in place immediately prior to their transition to Health Home.

The Plan will contract with providers who have expertise in caring for medically fragile children to ensure that medically fragile children, including children with co-occurring developmental disabilities, receive services from appropriate providers. Network providers will refer to appropriate network community and facility providers to meet the needs of the child or seek authorization from the plan for out-of-network providers when participating providers cannot meet the child's needs.

The Plan will be required to contract with OASAS residential programs and pay their allied clinical service providers on a single case or contracted basis for members who are placed in an OASAS-certified

residential program to ensure access to and continuity of care for patients placed outside of the Plan's service area.

The Plan shall ensure that all HCBS will be paid according to the NYS fee schedule as long as the Plan is not at risk for the service costs (e.g., for at least two years or until HCBS are included in the capitated rates).

The Plan shall execute Single Case Agreements (SCAs) with non-participating providers to meet clinical needs of children when in-network services are not available. The Plan must pay at least the fee-for-service fee schedule for 24 months for all SCAs.

FAIR HEARING PROCESS

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

- A. A practitioners' and organizational providers' first level of appeal regarding Beacon's National Credentialing Committee (NCC) decisions is through the provider appeals process.
- B. For issues related to professional competence and conduct, MDs, DOs, or any other provider, where required by federal or state statute/regulation or client requirement, are offered a fair hearing (second level of appeal).
- C. The practitioner/provider must request a fair hearing in writing within 30 calendar days of the Provider Appeals Committee's determination notification.
- D. Fair hearings must be held within 90 days of receipt of the written request, or less as required by applicable federal or state statutes/regulations. The practitioner/organizational provider will receive written notice, via certified mail, of the place, time, and date of the hearing, and any witnesses expected to testify on behalf of Beacon. This notice shall also specify a practitioner's/provider's rights related to the fair hearing, including rights provided under the HCQIA.
- E. Beacon's National Networks Management identifies professional peer reviewers who participate as the Fair Hearing Panel, assuring representation of the discipline of the practitioner/provider requesting the hearing. The hearing panel is composed of a minimum of three panel members, of which the majority will be the same discipline and the same or similar specialty as the health care professional under review. Professional peer reviewers do not have any economic interest averse to the practitioner/provider requesting the hearing. The Fair Hearing Panel selects an individual mutually acceptable to the practitioner/provider and Beacon to serve as the hearing officer, who may or may not be from the panel and who is also not in direct economic competition with the practitioner/provider involved.
- F. Reasonable efforts are made by both the practitioner/provider and Beacon to establish a mutually agreed upon date, time, and location for the fair hearing. The fair hearing may occur telephonically or in person as agreed upon by the participants. The practitioner's/provider's right to a hearing may be forfeited if the practitioner/provider fails, without good cause, to appear.
- G. The Fair Hearing Panel reviews all documentation including the NCC's decision, the Provider Appeals Committee's decision, and any additional information supplied by the practitioner/provider and witnesses present at the fair hearing proceedings.

- H. The practitioner/provider and Beacon each have the right to legal representation or other person of the practitioner's/provider's choice at the fair hearing proceedings.
- I. Beacon records the fair hearing proceedings and makes a written transcript of the proceedings available to the practitioner/provider at their request.
- J. During the fair hearing proceeding, the practitioner/provider and Beacon have the right to:
 - a. Call, examine, and cross-examine witnesses
 - b. Present evidence determined to be relevant by the hearing officer or review panel, regardless of its admissibility in a court of law
 - c. Submit a written statement at the close of the proceedings
- K. The chairperson of the Provider Appeals Committee provides written notification, via certified mail, of the Fair Hearing Panel's decision to the practitioner/provider within 15 business days of the date of the fair hearing proceedings, including a statement of the basis for the decision.
- L. Practitioners/providers may file an appeal with the appropriate state agency if they disagree with the Fair Hearing Panel's decision.
- M. All records and documentation, including transcripts, related to the fair hearing proceedings are retained for a minimum of seven years or longer as mandated by federal or state law or individual contract requirements.

3.3. Provider Credentialing and Recredentialing

Beacon will complete credentialing activities and notify providers within 90 days of receiving a completed application. Providers will be notified as to whether they are credentialed, if additional information is required, if additional time is required to complete the credentialing, or if Beacon is not in need of additional providers. If additional information is needed, the provider will be notified as soon as possible, but no more than 90 days from the receipt of the application.

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

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

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

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

or provider schools and facilities, evidence of current state licensure shall also serve as primary source verification of education and training.

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

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

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

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

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

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

- a. Applications found to be incomplete will either be sent back to the provider with a letter indicating the specific missing information or up to three outreach calls will be made to obtain the missing information.
- b. The practitioner will be given 10 - 30 days to respond to initial notice. Specific timeframe to respond will be indicated in the notice.
 - i. If the practitioner fails to respond within this time frame, Beacon may elect to discontinue the credentialing process.
 - ii. If Beacon elects to terminate the credentialing process, Beacon will notify the practitioner in writing.

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

MEDICAID PROVIDER DESIGNATION

In order to provide services to eligible individuals, a program must be designated by NYS to provide a specific service and contracted by Beacon to provide that service.

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

- National Practitioner Data Bank (NPDB)
- OIG Exclusion
- OMIG Exclusion
- SAM Exclusion
- New York DOH HCBS Designation List Check

State designation of providers will suffice for the Beacon's credentialing process. When contracting with NYS-designated providers, Beacon may not separately credential individual staff members in their capacity as employees of these programs.

HOME AND COMMUNITY BASED PROVIDER DESIGNATION

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

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

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

State designation of BH HCBS providers will suffice for Beacon's credentialing process. When contracting with NYS-designated BH HCBS providers, Beacon may not separately credential individual staff members in their capacity as employees of these programs. Beacon must still conduct program integrity reviews to ensure that BH HCBS provider staff are not disbarred from Medicaid or any other way excluded from Medicaid reimbursement.

Providers of Home and Community Based Services (HCBS) to children under 21 years of age authorized under the Children's 1115 Waiver amendment are required to conduct Criminal History Record Checks (CHRC), including finger printing, on prospective employees and Statewide Central Register (SCR) Database Checks on prospective employees. State training materials outlining the requirements may be found at www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.

OMH-LICENSED AND OASAS CERTIFIED BEHAVIORAL HEALTH PROVIDERS

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

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

RECREDENTIALING

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

- Licensure
- Clinical privileges
- Board certification
- Beacon shall query the NPDB and obtain updated sanction or restriction information from licensing agencies, Medicare, and Medicaid.
- Beacon does not perform site visits on practitioners or groups for recredentialing. A site visit may be requested if the practitioner meets the threshold established for number of complaints received. Site visits, medical record audits, including evaluation of the quality of encounter notes, are performed randomly by the Clinical Department for quality of care and compliance review. These site visits are not performed by the Network Management Department, except for those facilities that are not accredited at the time of recredentialing.

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

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

3.4. Organizational Credentialing

In order to be credentialed, facilities must be licensed or certified by the state in which they operate, and the license must be in force and in good standing at the time of credentialing or recredentialing. If the facility reports accreditation by The Joint Commission (TJC), Council on Accreditation of Services for Family and Children (COA), Healthcare Facilities Accreditation Program (HFAP), Accreditation Associated for Ambulatory Health Care (AAAHC), Community Health Accreditation Partner (CHAP), or Council on Accreditation of Rehabilitation Facilities(CARF), such accreditation must be in force and in good standing at the time of credentialing or recredentialing of the facility. If the facility is not accredited

by one of these accreditation organizations, Beacon conducts a site visit prior to rendering a credentialing decision.

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

For AmidaCare, Affinity, and MetroPlus Plans:

- Master's degree or above in a mental health field (including, but not restricted to, counseling, family therapy, psychology, etc.) from an accredited college or university AND eligible for licensure to practice independently in the state in which he/she works
- Supervised in the provision of services by a licensed independent clinical social worker, a licensed psychologist, a licensed master's-level clinical nurse specialist, or licensed psychiatrist meeting the contractor's credentialing requirements;
- Is covered by the hospital or mental health/substance abuse agency's professional liability coverage at a minimum of \$1,000,000/\$3,000,000
- Absence of Medicare/Medicaid sanctions

For Emblem Health and VNSNY Plans:

- Master's degree or above in a mental health field (including, but not restricted to, counseling, family therapy, psychology, etc.) from an accredited college or university AND licensed to practice in the state in which he/she works.
- Interns and non-licensed or certified clinicians are not accepted
- Is covered by the hospital or mental health/substance abuse agency's professional liability coverage at a minimum of \$1,000,000/\$3,000,000
- Absence of Medicare/Medicaid sanctions

Once the facility has been approved for credentialing and contracted with Beacon to serve members of one or more health plans, all licensed or certified behavioral health professionals listed may treat members in the facility setting.

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

3.5. Credentialing Process Overview

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

INDIVIDUAL PRACTITIONER CREDENTIALING	ORGANIZATIONAL CREDENTIALING
<ul style="list-style-type: none"> ▪ Licensed Psychologist ▪ Licensed Independent Clinical Social Worker ▪ Licensed Independent Counselor ▪ Master's-Level Clinical Nurse Specialists/Psychiatric Nurses ▪ Licensed Mental Health Counselors ▪ Licensed Marriage and Family Therapists ▪ Other behavioral healthcare specialists who are master's level or above and who are independently licensed, certified, or registered by the state in which they practice 	<ul style="list-style-type: none"> ▪ Licensed outpatient clinics and agencies, including hospital-based clinics ▪ Freestanding inpatient mental health facilities – freestanding and within general hospital ▪ Inpatient mental health units at general hospitals ▪ Inpatient detoxification facilities ▪ Other diversionary mental health and substance use disorder services including: <ol style="list-style-type: none"> 1. Partial hospitalization 2. Day treatment 3. Intensive outpatient 4. Residential 5. Substance use rehabilitation

3.6. Waiver Request Process

On occasions in which a provider possesses unique skills or abilities but does not meet the above credentialing criteria, a Beacon Waiver Request Form should be submitted. These waiver request forms will be reviewed by the Beacon Credentialing Committee, and providers will be notified of the outcome of the request.

3.7. Provider Training

TRAINING PROGRAM OVERVIEW

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

This training provides an overview of HCBS including:

- Overview and purpose of the waiver services
- Medical necessity
- Prior authorization process
- Care planning – person-centered planning process

- Independent evaluations
- Qualifications for providers
- What is a critical incident and what are the reporting requirements?
- Claims submission

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

TIMING

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

STANDARD TRAINING TIMELINE

New Providers

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

Annual Trainings

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

CULTURAL COMPETENCY

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

C h a p t e r 4

Encounter Data and Submitting HCBS Billing and Claims

-
- 4.1. General Claims Policies
 - 4.2. Electronic Billing Requirements
 - 4.3. Paper Claims Transactions
 - 4.4. Additional Claims Information/Requirements
 - 4.5. Provider Education and Outreach
 - 4.6 Coding
 - 4.7. Billing of Expanded Services
-

4.1. General Claims Policies

This chapter presents all information needed to submit claims to Beacon. Beacon strongly encourages providers to rely on electronic submission, either through EDI or eServices in order to achieve the highest success rate of first-submission claims. Please note that Beacon does not accept claims submitted by facsimile.

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

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

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

DEFINITION OF A “CLEAN CLAIM”

A clean claim, as discussed in this provider manual, the Provider Services Agreement, and in other Beacon informational materials, is defined as one that has no defect and is complete, including required data elements, and when applicable, substantiating documentation of particular circumstance(s) warranting special treatment without which timely payments on the claim would not be possible. All claims received by Beacon will be paid or denied within 30 days of receipt determined by the day Beacon receives the claim.

TIME LIMITS FOR FILING CLAIMS

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

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

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

ICD-10 COMPLIANCE

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

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

4.2. Electronic Billing

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

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

- **Electronic Data Interchange (EDI)** supports electronic submission of claim batches in HIPAA-compliant 837P format for professional services and 837I format for institutional services. Providers may submit claims using EDI/837 format directly to Beacon or through a billing intermediary. If using Emdeon as the billing intermediary, two identification numbers must be included in the 837 file for adjudication:
 - Beacon's payor ID is 43324
 - Your Health Plan's EDI Code. Please refer to the health plan-specific contact information at the end of this manual for your Plan ID.
- **eServices** enables providers to submit inpatient and outpatient claims without completing a CMS 1500 or UB04 claim form. Because much of the required information is available in Beacon's database, most claim submissions take less than one minute and contain few, if any errors. Please call Beacon's Provider Relations for additional information on eServices.

ADDITIONAL INFORMATION AVAILABLE ONLINE:

- Read *About eServices*
- eServices User Manual
- Read *About EDI*
- EDI Transactions - 837 Companion Guide
- EDI Transactions - 835 Companion Guide
- EDI Transactions - 270-271 Companion Guide

VALUEOPTIONS' CONTRACTED PROVIDERS

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

ProviderConnect

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

and electronic access to authorization/certification letters from ValueOptions and provider summary vouchers.

Clearinghouses

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

PaySpan® Health

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

Beacon's Electronic Data Interchange (EDI) Claims Link for Windows® Software

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

Beaconhealthoptions.com

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

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

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

Claim Submission Guidelines

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

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

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

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

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

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

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

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

CLAIMS TRANSACTION OVERVIEW

The table below identifies all claims transactions and indicates which transactions are available on each of the electronic media and provides other information necessary for electronic completion. Watch for updates as additional transactions become available on EDI, eServices, and IVR.

TRANSACTION	EDI	E SERVICES	IVR	APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
Member Eligibility Verification	Y	Y	Y	<ul style="list-style-type: none">▪ Completing any claim transaction;▪ Submitting clinical authorization requests	N/A	N/A
Submit Standard Claim	Y	Y	Y	<ul style="list-style-type: none">▪ Submitting a claim for authorized, covered	Within the plan's filing limit from the date of service.	N/A

TRANSACTION	EDI	ESERVICES	IVR	APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
				services, within the timely filing limit	Please refer to the health plan-specific contact information at the end of this manual for the filing limit.	
Resubmission of Denied Claim	Y	Y	Y	Previous claim was denied for any reason except timely filing	Within the plan's filing limit from the date on the EOB. Please refer to the health plan-specific contact information at the end of this manual for the filing limit.	<ul style="list-style-type: none"> ▪ Claims denied for late filing may be resubmitted as reconsiderations. ▪ Rec ID is required to indicate that claim is a resubmission.
Waiver* (Request for waiver of timely filing limit) <i>Please refer to the health plan-specific addendum for your plan's filing limit)</i>	N	N	N	A claim being submitted for the first time will be received by Beacon after the original plan filing limit (please refer to the health plan-specific addendum for your plan's filing limit, and must include evidence that one of the following conditions is met: ▪ Provider is eligible for reimbursement retroactively	Within the filing limit) from the qualifying event. Please refer to the health plan-specific contact information at the end of this manual for your plan's filing limit.	<ul style="list-style-type: none"> ▪ Waiver requests will be considered only for these four circumstances. A waiver request that presents a reason not listed here, will result in a claim denial on a future EOB. ▪ A claim submitted beyond the filing limit that does not meet the above criteria may be submitted as a reconsideration request.

TRANSACTION	EDI	ESERVICES	IVR	APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
				<ul style="list-style-type: none"> ▪ Member was enrolled in health plan retroactively ▪ Services were authorized retroactively ▪ Third party coverage is available and was billed first. (A copy of the other insurance explanation of benefits (EOB) or payment is required.) You still have to be within the filing limit when submitting an EOB for coordination of benefits. 		<ul style="list-style-type: none"> ▪ Beacon's waiver determination is reflected on a future EOB with a message of "Waiver Approved" or "Waiver Denied": if waiver of the filing limit is approved, the claim appears adjudicated; if the request is denied, the denial reason appears.
Request for Reconsideration of Timely Filing Limit*	N	Y	N	Claim falls outside of all time frames and requirements for resubmission, waiver and adjustment	Within the filing limit from the date of payment or nonpayment. Please refer to the health plan-specific contact information at the end of this manual for the plan's filing limit.	Future EOB shows "Reconsideration Approved" or "Reconsideration Denied" with denial reason

TRANSACTION	EDI	ESERVICES	IVR	APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
Request to Void Payment	N	N	N	<ul style="list-style-type: none"> ▪ Claim was paid to provider in error; and ▪ Provider needs to return the entire paid amount to Beacon 	N/A	Do NOT send a refund check to Beacon
Request for Adjustment	Y	Y	Y	<p>The amount paid to provider on a claim was incorrect</p> <p>Adjustment may be requested to correct:</p> <ul style="list-style-type: none"> ▪ Underpayment (positive request); or ▪ Overpayment (negative request) 	<p>Positive request must be received by Beacon within the plan's filing limit) from the date of original payment.</p> <p>Please refer to the health plan-specific contact information at the end of this manual for the plan's filing limit.</p> <p>No filing limit applies to negative requests</p>	<ul style="list-style-type: none"> ▪ Do NOT send a refund check to Beacon. ▪ A Rec ID is required to indicate that claim is an adjustment. ▪ Adjustments are reflected on a future EOB as recoupment of the previous (incorrect) amount, and if money is owed to provider, repayment of the claim at the correct amount ▪ If an adjustment appears on an EOB and is not correct, another adjustment request may be submitted based on the previous incorrect adjustment

TRANSACTION	EDI	ESERVICES	IVR	APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
						<ul style="list-style-type: none"> ▪ Claims that have been denied cannot be adjusted, but may be resubmitted.
Obtain Claim Status	N	Y	Y	Available 24/7 for all claims transactions submitted by provider	N/A	Claim status is posted within 48 hours after receipt by Beacon.
View/Print Remittance Advice (RA)	N	N	N	Available 24/7 for all claims transactions received by Beacon	N/A	Printable RA is posted within 48 hours after receipt by Beacon.

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

Beacon Discourages Paper Transactions

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

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

4.3. Paper Claims Transactions

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

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

WHERE TO SEND CLAIMS

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

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

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

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

Instructions for completion of each claim type are provided below.

Professional Services: Instructions for Completing the CMS 1500 Form

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

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

TABLE BLOCK #	REQUIRED?	DESCRIPTION
10a-c	No	Member's Condition Related to Employment
11	No	Member's Policy, Group, or FICA Number (if applicable)
11a	No	Member's Date of Birth (MM, DD, YY) and Sex (check box)
11b	No	Employer's Name or School Name (if applicable)
11c	No	Insurance Plan Name or Program Name (if applicable)
11d	No	Is there another health benefit plan?
12	No	Member's or Authorized Person's Signature and Date on File
13	No	Member's Authorized Signature
14	No	Date of Current Illness
15	No	Date of Same or Similar Illness
16	No	Date Client Unable to Work in Current Occupation
17	No	Name of Referring Physician or Other Source (if applicable)
17B	No	NPI of Referring Physician
18	No	Hospitalization dates Related to Current Services (if applicable)
19	No	Additional Claim Information (Designated by NUCC), if applicable. (Record ID if applicable)
20	No	Outside Lab?
21	Yes	Diagnosis or Nature of Illness or Injury. Enter the applicable ICD indicator according to the following: 9 – ICD-9 diagnosis or 0 – ICD-10-CM diagnosis
22	No	Medicaid Resubmission Code or Former Control Number
23	No	Prior Authorization Number (if applicable)
24a	Yes	Date of Service
24b	Yes	Place of Service Code (HIPAA-compliant)
24d	Yes	Procedure Code and modifier, when applicable

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

Institutional Services: Instructions for Completing the UB04 Form

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

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

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

TABLE BLOCK #	REQUIRED?	DESCRIPTION
39-41	No	Value CD/AMT
42	Yes	Revenue Code (if applicable)
43	Yes	Revenue Description
44	Yes	Procedure Code (CPT) (Modifier may be placed here beside the HCPCS code)
45	Yes	Service Date
46	Yes	Units of Service
47	Yes	Total Charges
48	No	Non-Covered Charges
49	Yes	Modifier (if applicable)
50	No	Payer Name
51	Yes	Beacon Provider ID Number
52	Yes	Release of Information Authorization Indicator
53	Yes	Assignment of Benefits Authorization Indicator
54	Yes	Prior Payments (if applicable)
55	No	Estimated Amount Due
56	Yes	Facility NPI
57	No	Other ID
58	No	Insured's Name
59	No	Member's Relationship to Insured
60	Yes	Member's Identification Number
61	No	Group Name
62	No	Insurance Group Number
63	Yes	Prior Authorization Number (if applicable)

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

PAPER RESUBMISSION

- See earlier table for an explanation of claim resubmission, when resubmission is appropriate, and procedural guidelines.
- If the resubmitted claim is received by Beacon later than allowed by the plan's filing limit (please refer to the health plan-specific contact information at the end of this manual for the plan's filing limit) from the date of service, the REC.ID from the denied claim line is required and may be provided in either of the following ways:
 - Enter the original claim number in box 64 on the UB04 claim form or in box 19 on the CMS 1500 form.
 - Submit the corrected claim with a copy of the EOB for the corresponding date of service.

- The original claim number corresponds with a single claim line on the Beacon EOB. Therefore, if a claim has multiple lines, there will be multiple original claim number numbers on the Beacon EOB.
- The entire claim that includes the denied claim line(s) may be resubmitted regardless of the number of claim lines; Beacon does not require one line per claim form for resubmission. When resubmitting a multiple-line claim, it is best to attach a copy of the corresponding EOB.
- Resubmitted claims cannot contain original (new) claim lines along with resubmitted claim lines.
- Resubmissions must be received by Beacon within the plan's filing limit from the date on the EOB. Please refer to the health plan-specific contact information at the end of this manual for the plan's filing limit.

Paper Request for Adjustment or Void

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

4.4. Additional Claims Information/Requirements

CHANGE OF CLAIMS FILING ADDRESS

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

CATASTROPHIC EVENT

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

CLAIMS INQUIRIES AND RESOURCES

Additional information is available through the following resources:

Online

- Beacon Claims Page
- Read About eServices
- eServices User Manual

- Read About EDI
- EDI Transactions - 837 Companion Guide
- EDI Transactions - 835 Companion Guide
- EDI Transactions - 270-271 Companion Guide

Email Contact

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

Beacon Main Telephone Numbers:

Beacon Health Options.....	855.371.9228
Main fax number.....	781.994.7600
TTY Number (for hearing impaired).....	866.727.9441
Provider Relations.....	855.371.9228
Provider Relations fax.....	781.994.7639
Credentialing fax.....	781.994.7667
Provider Relations email:.....	provider.relations@beaconhealthoptions.com
Claims Hotline.....	888.249.0478
eServices Helpline.....	866.206.6120

4.5. Provider Education and Outreach

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

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

How the Program Works

- A quarterly approval report is generated that lists the percentage of claims paid in relation to the volume of claims submitted.
- All providers below 75 percent approval rate have an additional report generated listing their most common denials and the percentage of claims they reflect.

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

Complaints and Grievances

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

Appeals of Complaint/Grievance Resolutions

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

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

CLAIMS FOR INPATIENT SERVICES

- The date range on an inpatient claim for an entire admission (i.e., not an interim bill) must include the admission date through the discharge date. The discharge date is not a covered day of service but must be included as the "to" date.
- Beacon accepts claims for interim billing that include the last day to be paid as well as the correct bill type and discharge status code. On bill type XI3, where X represents the "type of facility" variable, the last date of service included on the claim will be paid and is not considered the discharge day.

RECOUPMENTS AND ADJUSTMENTS BY BEACON

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

LIMITED USE OF INFORMATION

All information supplied by Beacon Health Options or collected internally within the computing and accounting systems of a provider or billing agency (e.g., member files or statistical data) can be used only by the provider in the accurate accounting of claims containing or referencing that information. Any redistributed or dissemination of that information by the provider for any purpose other than the accurate accounting of behavioral health claims is considered an illegal use of confidential information.

PROHIBITION OF BILLING MEMBERS

Providers are not permitted to bill health plan members under any circumstances for covered services rendered, excluding co-payments when appropriate.

4.6. Coding

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

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

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

BILL TYPE CODES

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

TYPE OF FACILITY 1ST DIGIT

Hospital	1
Skilled Nursing	2
Home Health	3
Religious Non-Medical	4
Reserved for National Assignment	5

TYPE OF FACILITY 1ST DIGIT

Intermediate Care	6
Clinic	7
Specialty Facility	8
Reserved for National Use	9

BILL CLASSIFICATION (EXCEPT CLINICS AND SPECIAL FACILITIES) 2ND DIGIT

Inpatient (including Medicare Part A)	1
Inpatient (Medicare Part B Only)	2
Outpatient	3
Diagnostic Services	4
Intermediate Care – Level I	5
Intermediate Care – Level II	6
Reserved for National Assignment	7
Swing Bed	8
Reserved for National Use	9

BILL CLASSIFICATION (CLINICS ONLY) 2ND DIGIT

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

Reserved for National Use	7-8
Other	9

BILL CLASSIFICATION (SPECIAL FACILITIES ONLY) 2ND DIGIT

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

FREQUENCY 3RD DIGIT

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

OTHER BILL TYPES

77X – Federally Qualified Health Centers

MODIFIERS

Modifiers can reflect the discipline and licensure status of the treating practitioner or are used to make up specific code sets that are applied to identify services for correct payment. Please see your specific contract for the list of contracted modifiers.

BEACON'S RIGHT TO REJECT CLAIMS

At any time, Beacon can return, reject or disallow any claim, group of claims, or submission received pending correction or explanation.

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

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

4.7. Billing of Expanded Services

ASSERTIVE COMMUNITY TREATMENT (ACT)

Members over 18 years of age might be eligible for ACT services. ACT services are billed once per month using one rate code for the month's services. There are three types of monthly payments which are dependent on the number and type of contacts with the recipient or collaterals: full, partial or inpatient. Claims are submitted using the last day of the month in which the services were rendered as the date of service. A contact or unit of service is defined as a face-to-face interaction of at least 15 minutes in duration where at least one ACT service is provided between an ACT team staff member and the recipient or collateral. Providers should use the per diem code, with number of contacts during month in the unit field.

ACT services should be billed on an 837I.

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

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

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

OASAS-Certified Clinic

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

OUTPATIENT PROGRAMS

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

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

OPIOID TREATMENT PROGRAMS (OTP)

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

OUTPATIENT REHABILITATION

Chemical dependence outpatient rehabilitation services (outpatient rehabilitation services) are services provided by an outpatient program which has been certified by OASAS to provide outpatient rehabilitation services; such services are designed to assist individuals with more chronic conditions who are typically scheduled to attend the outpatient rehabilitation program three to five days per week for at least four hours per day. (Part 822.15 (i)) outpatient rehabilitation services for individuals with more chronic conditions emphasize development of basic skills in prevocational and vocational competencies, personal care, nutrition, and community competency. These services are provided in combination with all other clinical services provided by outpatient programs. If an outpatient program is providing outpatient rehabilitation services, the following services must be available either directly or through written agreements: (1) socialization development; (2) skill development in accessing community services; (3) activity therapies; and (4) information and education about nutritional requirements, including but not

limited to planning, food purchasing, preparation and clean-up. (e) A provider of outpatient rehabilitation services must assure the availability of one meal to each patient who receives outpatient rehabilitation services for four or more hours per day (Part 822.15 (a) (d) (e). In New York these are delivered in OASAS outpatient settings Certified by Title 14 NYCRR Part 822.

OASAS RATE CODES

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

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

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

CODE TABLE	RATE CODE (SAME AS APG RATE CODE)
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Program	1468
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Rehab Program	1570
Part 822 Community (Art 28/32) Opiate Treatment Program	1471

CONTINUING DAY TREATMENT (CDT)

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

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

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

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

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

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIERS	UNITS OF SERVICE
4317	CDT Full Day 41-64	H2012	Behavioral Health Day Treatment, per hour	U2	4-5
4318	CDT Full Day 65+	H2012	Behavioral Health Day Treatment, per hour	U3	4-5
4325	CDT Collateral	H2012	Behavioral Health Day Treatment, per hour	UK	1
4331	CDT Group Collateral	H2012	Behavioral Health Day Treatment, per hour	UK, HQ	1
4337	CDT Crisis	H2012	Behavioral Health Day Treatment, per hour	U8	1
4346	CDT Pre-Admission	H2012	Behavioral Health Day Treatment, per hour	U9	1

CPEP

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

Claiming for Extended Observation Beds:

- Admission to the extended observation bed is, for billing purposes, the calendar day after the calendar day in which the full or brief visit is completed.
- The extended observation bed rate may only be claimed when a person has been held in the CPEP for more than 24 hours.
- A brief or full visit claim is submitted for the calendar day in which the visit is completed, and claims for the extended observation bed are submitted for each subsequent day, up to 72 hours from the patient's initial arrival in the CPEP.

- If the patient is admitted to the psychiatric inpatient unit, the extended observation bed rate is not claimed. The psychiatric inpatient unit rate is claimed instead beginning on admission to the extended observation bed

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

PARTIAL HOSPITALIZATION

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4356	Partial Group Collateral - 2 Hours	H0035	Mental Health Partial Hosp. Treatment under 24 Hours	U2, HQ, HR or HS	2	Billed daily. Code with 2 units. Use HQ (group) modifier. Also use HR or HS modifier (in addition to HQ and U2). This code does not pay in APGs.
4357	Partial Hospitalization Crisis – 1 Hour	S9484	Crisis Intervention per hour	HK, U1, [UA]	1	Pays in APGs. Use HK modifier to differentiate claim from clinic (APGs). Billed daily. Add the UA modifier if the service is a pre-admission.
4358	Partial Hospitalization Crisis – 2 Hours	S9484	Crisis Intervention per hour	HK, U2, [UA]	2	Pays in APGs. Use HK modifier to differentiate claim from clinic (APGs). Billed daily. Add the UA modifier if the service is a pre-admission.
4359	Partial Hospitalization Crisis – 3 Hours	S9484	Crisis Intervention per hour	HK, U3, [UA]	3	Pays in APGs. Use HK modifier to differentiate claim from clinic (APGs). Billed daily. Add the UA modifier if the service is a pre-admission.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4360	Partial Hospitalization Crisis – 4 Hours	S9484	Crisis Intervention per hour	HK, U4	4	Pays in APGs. Use HK modifier to differentiate claim from clinic (APGs). Billed daily.
4361	Partial Hospitalization Crisis – 5 Hours	S9484	Crisis Intervention per hour	HK, U5	5	Pays in APGs. Use HK modifier to differentiate claim. Billed daily.
4362	Partial Hospitalization Crisis – 6 Hours	S9484	Crisis Intervention per hour	HK, U6	6	Pays in APGs. Use HK modifier to differentiate claim from clinic (APGs). Billed daily.
4363	Partial Hospitalization Crisis – 7 Hours	S9484	Crisis Intervention per hour	HK, U7	7	Pays in APGs. Use HK modifier to differentiate claim from clinic (APGs). Billed daily.

PERSONALIZED RECOVERY OUTCOME SERVICES (PROS)

Members over 18 years of age might be eligible for PROS services. A comprehensive PROS program is reimbursed on a monthly case payment basis. PROS claims use the last day of the month as the date of service and that date represents all the days for that month. Therefore, all the line level dates of service must also be the last day of the month. Each unique procedure code/modifier code(s) combination should be recorded on its own claim, along with the corresponding units of service and the pre-managed care rate code in the header of the claim.

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

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4510	PROS Preadmission	H0002	Behavioral Health Screening, Admission Eligibility	HE	1	Billed monthly. The PROS units for the month are determined by using the "PROS Unit Conversion Chart" on a daily basis and then totaling for the month. Use the per diem code and show total PROS units for the month. The number of units coded does not affect payment, as payment is the same throughout the range.
4520	PROS Community Rehab Services, 2-12 units	H2019	Ther Behav Service, per 15 min	U1	2-12	Billed monthly. The PROS units for the month are determined by using the "PROS Unit Conversion Chart" on a daily basis and then totaling for the month. Use the per diem code and show total PROS units for the month. The number of units coded does not affect payment, as payment is the same throughout the range.

RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
4521	PROS Community Rehab Services, 13-27 units	H2019	Ther Behav Service, per 15 min	U2	13-27	Billed monthly. The PROS units for the month are determined by using the "PROS Unit Conversion Chart" on a daily basis and then totaling for the month. Use the per diem code and show total PROS units for the month. The number of units coded does not affect payment, as payment is the same throughout the range.
4522	PROS Community Rehab Services, 28-43 units	H2019	Ther Behav Service, per 15 min	U3	28-43	Billed monthly. Requires at least 2 units of PROS in the CRS base (billed on separate line using H2019 - and showing total PROS units for the month). The two "base" units could include CRS, Clinic, Intensive Rehab, or ORS. Show only 1 unit on this line.
4523	PROS Community Rehab	H2019	Ther Behav Service, per 15 min	U4	44-60	Billed monthly. Requires at least 6 units of PROS in the CRS base

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

4525	PROS Clinical Treatment Add-on	T1015	Clinic Visit/Encounter, All Inclusive	HE	1	Billed monthly. Used instead of rate code 4510, but only for the BIP population. Limited to 4 (instead of only 2) consecutive months. Cannot be billed in same month as PROS monthly base rate services
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RATE CODE	RATE CODE/ SERVICE TITLE	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	MODIFIER	UNITS OF SERVICE	NOTES
						code or other PROS rate codes. This code pays in APGs. Use HE modifier to differentiate claim from clinic (APGs).
4526	PROS Int. Rehab	H2018	Psysoc Rehab Service, per diem	HE	1	This is a monthly add-on to the base rate and can be billed in combination with other add-ons. Two or three services are required (see billing manual), but use one (1) as the billing unit.
4534	Intensive Rehab - AH/NH/PC	H2018	Psysoc Rehab Service, per diem	UB, HE	1	This code is used in place of 4526 for the BIP population. The billing requirements are the same as 4526, but also include the UB modifier.

OASAS RESIDENTIAL TREATMENT

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

rehabilitation services, stabilization treatment services, substance use disorder outpatient and opioid treatment programs.

REHABILITATION SERVICES IN A RESIDENTIAL SETTING

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

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

RESIDENTIAL REHABILITIATION SERVICES FOR (RRSY)

In July 2007, all short-term and long-term RCDY programs began converting to a new residential services that include the following enhanced staffing pattern. Medical Director, on-site medical staff, provision for psychological and psychiatric services and a community support specialist to help with case management and discharges planning. The staff to patient ratio is 1:8 and all programs are required to have a family therapist and/or social worker with family therapist experience.

RESIDENTIAL SUPPORTS AND SERVICES: Early Periodic Screening, Diagnostic and Treatment (EPSDT)

Provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventative, dental, mental health, developmental and specialty services.

RESIDENTIAL TREATMENT FACILITY (RTF)

A 24hour per day inpatient treatment program which provides intensive treatment services to children and adolescents age 5-21 who need longer term treatment than would be provided on an inpatient psychiatric program operated by general, private mental hospital, or state psychiatric center.

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

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

1. Patient-specific Tier 1 limit of \$8,000. Tier I services include employment, education and peer supports services.

2. Patient-specific overall HCBS (i.e., Tier 1 and Tier 2 combined) limit of \$16,000
3. Short-term crisis respite and intensive crisis respite are individually limited to 7 days per episode and 21 days per year.

When submitting claims for approved waiver program services:

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

Children and Family Treatment and Support Services Rate Code

The table below provides a summary of billing for Children and Family Treatment and Support Services (CFTSS). For a detailed guide on how to bill these services please reference the [NYS Billing Manual](#).

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
OLP Licensed Evaluation	7900	90791	EP	15 Minutes	10
OLP Counseling -Individual	7901	H0004	EP	15 Minutes	4
OLP Counseling – Family (with or without the client present)	7901	H0004	HR – Family with client HS – Family without client	15 Minutes	4
OLP Crisis (Offsite, In-person only)	7902	H2011	EP, ET	15 Minutes	8
OLP Crisis Triage (By Phone)	7903	H2011	EP, GT	15 Minutes	2
OLP Crisis Complex Care (Follow up)	7904	90882	EP, TS	5 Minutes	4
OLP Counseling - Group	7905	H0004	HQ, EP	15 Minutes	4

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Offsite – OLP Evaluation, Individual or Family (with or without the client present)	7920	90791 or H0004 depending on service provided	90791- EP, SC - Evaluation H0004 -SC - Individual H0004 – HR, SC – Family with client H0004 – HS, SC – Family without client	15 Minutes	10 for Evaluation 4 for Individual or Family Counseling
Offsite – OLP Counseling Group	7927	H0004	EP, HQ, SC	15 Minutes	4
CPST Service Professional – Individual and/or Family (with or without the client)	7911	H0036	EP	15 Minutes	6
CPST Service Professional -Group	7912	H0036	EP, HQ	15 Minutes	4
Offsite- CPST Individual and/or Family (with or without the client)	7921	H0036	EP, SC	15 Minutes	6
Offsite – CPST Group	7928	H0036	EP, HQ, SC	15 Minutes	4
PSR Service Professional	7913	H2017	EP	15 Minutes	8
PSR Service Professional -Group	7914	H2017	EP, HQ	15 Minutes	4

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Offsite- PSR Individual	7922	H2017	EP, SC	15 Minutes	8
Offsite – PSR Group	7929	H2017	EP, HQ, SC	15 Minutes	4
FPS Service Professional	7915	H0038	EP, UK	15 Minutes	8
FPS Service Professional -Group	7916	H0038	EP, UK, HQ	15 Minutes	6
Offsite- FPS/YPS - Individual	7923	H0038	EP, UK, SC	15 Minutes	8
Offsite – FPSS/YPST -Group	7930	H0038	EP, HQ, SC, UK	15 Minutes	6
YPS Service Professional	7917	H0038	EP	15 Minutes	8
YPS Service Professional -Group	7918	H0038	EP, HQ	15 Minutes	6
Offsite- FPS/YPS - Individual	7923	H0038	EP, SC	15 Minutes	8
Offsite – FPSS/YPST Group	7930	H0038	EP, HQ, SC	15 Minutes	6

Mobile Crisis					
One-person response: Licensed	7906	H2011	EP, HO	15 Minutes	6/day
Two-person Response: Licensed and Unlicensed/Certified Peer	7907	H2011	EP, HT	15 Minutes	6/day
Two-person Response: Both Licensed	7908	H2011	EP	15 Minutes	6/day
Two-person Response: Licensed and Unlicensed/Certified Peer	7909	S9484	EP	Per Diem	1/day
Two-person Response: Licensed and Unlicensed/Certified Peer	7910	S9485	EP	Per Diem	1/day
Two Person Response: Both Licensed (90-180 minutes)	7936	S9484	EP, HO	Per diem (90- 180 minutes)	1/day
Two Person Response: Both Licensed (over 3 hours)	7937	S9485	EP, HO	Per diem greater than 180 minutes	1/day
Mobile Follow up Services					
One Person Face-to- Face Follow-Up: Licensed	7938	H2011	TS, HO	15 minutes	6/day
One Person Face-to- Face Follow-Up: Unlicensed/Certified Peer	7939	H2011	TS, HM, HA	15 minutes	6/day
Two-person Face-to- Face Follow-Up: Licensed and Unlicensed	7940	H2011	TS, HT	15 minutes	6/day
Telephonic Follow up Services					

Telephonic Follow-Up: Licensed	7941	H2011	TS, HO, GT	15 minutes	4/day
CI Telephonic follow up Unlicensed/Certified Peer	7942	H2011	TS, HM, GT	15 minutes	4/day

Crisis Residential Services

Residential Crisis Support	7943	H2013	HA, TF	per diem	1/day
Intensive Crisis Residence (ICR) 18-20 years	7944	H2013	HA, HK	per diem	1/day
Children's Crisis Residence	7945	H2013	HA	per diem	1/day

Program Type	Age Range	Rate Code	CPT Code	Modifier	Unit Measure	Length of Stay Limit
Children's Crisis Residence	Under 21	7945	H2013	HA	Per Diem	28 days per admission; unless otherwise approved by MMCP/OMH
Residential Crisis Support	18-20	7943	H2013	HA, TF	Per Diem	28 days per admission
Intensive Crisis Residence	18-20	7944	H2013	HA, HK	Per Diem	28 days per admission

Children HCBS Services Rate Code

The table below provides a summary of billing for Children HCBS Services. For a detailed guide on how to bill these services please reference the [NYS Billing Manual](#).

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Caregiver Family Supports and Services - Individual	8003	H2014	UK, HA	15 minutes	12
Caregiver Family Supports and Services - Group of 2	8004	H2014	HA, UK, UN	15 minutes	12
Caregiver Family Supports and Services - Group of 3	8005	H2014	HA, UK, UP	15 minutes	12
Prevocational Services -Individual	8006	T2015	HA	Per hour	2
Prevocational Services -Group of 2	8007	T2015	HA, UN	Per hour	2
Prevocational Services -Group of 3	8008	T2015	HA, UP	Per hour	2
Community Advocacy and Support -Individual	8009	H2015	HA	15 minutes	12
Community Advocacy and Support -Group of 2	8010	H2015	HA, UN	15 minutes	12
Community Advocacy and Support -Group of 3	8011	H2015	HA, UP	15 minutes	12

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Supported Employment	8015	H2023	HA	15 minutes	12
Palliative Care Pain and Symptom Management	8016	99342	TJ	30 minutes	No limit, as required by participant's physician
Palliative Care Pain and Symptom Management	8016	99347	TJ	15 minutes	No limit, as required by participant's physician
Palliative Care Bereavement Services	8017	90832	TJ	30 minutes	Limited to the lesser of 5 appointments per month or 60 hours per calendar year
Palliative Care Massage Therapy	8018	97124	TJ	15 minutes	12 appointment limits can be exceeded when medically necessary
Palliative Care Expressive Therapy	8019	96152	TJ	15 minutes	48 limit can be exceeded when medically necessary
Planned Respite - Individual (under 4 hours)	8023	S5150	HA	15 minutes	16

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Planned Respite - Individual per diem (4+ hours)	8024	S5151	HA	Per Diem	1
Planned Respite - Group (under 4 hours)	8027	S5150	HA, HQ	15 minutes	16
Crisis Respite - under 4 hours	8028	S5150	HA, ET	15 minutes	16
Crisis Respite – more than 4 hours, less than 12 hours	8029	S5151	HA, ET	Per Diem	1
Crisis Respite - Individual (12+ hours, less than 24 hours)	8030	S5151	HA, ET, HK	Per Diem	1
Day HCBS Habilitation	7933	T2020	HA	15 minutes	24
Day HCBS Habilitation - Group of 2	7934	T2020	HA, UN	15 minutes	24
Day HCBS Habilitation - Group of 3 or more	7935	T2020	HA, UP	15 minutes	24
Community HCBS Habilitation	8012	H2014	HA	15 minutes	24
Community HCBS Habilitation - Group of 2	8013	H2014	HA, UN	15 minutes	24
Community HCBS Habilitation - Group of 3 or more	8014	H2014	HA, UP	15 minutes	24

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Environmental Modifications	8032	S5165	HA	\$1.00	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.
Environmental Modifications	8034	S5165	HA, V1	\$10.00	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.
Environmental Modifications	8035	S5165	HA, V2	\$100.00	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Environmental Modifications	8036	S5165	HA, V3	\$1000.00	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.
Vehicle Modifications	8041	T2039	HA	\$1.00	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.
Vehicle Modifications	8042	T2039	HA, V1	\$10.00	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Vehicle Modifications	8043	T2039	HA, V2	\$100.00	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.
Vehicle Modifications	8044	T2039	HA, V3	\$1000.00	May not exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.
Adaptive and Assistive Equipment	8037	T2028	HA	\$1.00	Cannot exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.

SERVICE	RATE CODE	CPT CODE	MODIFIER	UNIT MEASURE	UNIT LIMIT/DAY
Adaptive and Assistive Equipment	8038	T2028	HA, V1	\$10.00	Cannot exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.
Adaptive and Assistive Equipment	8039	T2028	HA, V2	\$100.00	Cannot exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.
Adaptive and Assistive Equipment	8040	T2028	HA, V3	\$1000.00	Cannot exceed \$15,000 per year without prior approval. The State may consider exceptions when medically necessary.

C h a p t e r 5

Communicating with Beacon

- 5.1. Transactions and Communications with Beacon
 - 5.2 Electronic Media
 - 5.3 Communication of Member and Provider Information
 - 5.4 Beacon Provider Database
 - 5.5 Other Benefits Information
 - 5.6 Member Eligibility Verification Tools
 - 5.7 Provider Training
-

5.1. Transactions and Communications with Beacon

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

5.2. Electronic Media

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

ESERVICES

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

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

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

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

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

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

INTERACTIVE VOICE RECOGNITION (IVR)

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

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

ELECTRONIC TRANSACTIONS AVAILABILITY (WHEN BEACON IS A CLAIMS PAYOR)

TRANSACTION/CAPABILITY	AVAILABLE 24/7		
	eSERVICES	IVR	EDI
Verify member eligibility, benefits, and co-payments	Yes	Yes	Yes (HIPAA 270/271)
Check number of visits available	Yes	Yes	Yes (HIPAA 270/271)
Submit outpatient authorization requests	Yes	No	
View authorization status	Yes	Yes	
Update practice information	Yes	No	
Submit claims	Yes	No	Yes (HIPAA 837)
Upload EDI claims to Beacon and view EDI Upload history	Yes	No	Yes (HIPAA 837)
View claims status	Yes	No	Yes (HIPAA 835)
Print claims reports and graphs	Yes	No	
Download electronic remittance advice	Yes	No	Yes (HIPAA 835)
EDI acknowledgment and submission reports	Yes	No	Yes (HIPAA 835)
Pend authorization requests for internal	Yes	No	
Access Beacon's level of care criteria and provider manual	Yes	No	

EMAIL

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

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

5.3. Communication of Member and Provider Information

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

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

CONFIDENTIALITY OF HIV-RELATED INFORMATION

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

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

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

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

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

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

REQUIRED NOTIFICATIONS

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

TYPE OF INFORMATION	METHOD OF NOTIFICATION	
	eSERVICES	EMAIL
General Practice Information		

TYPE OF INFORMATION	METHOD OF NOTIFICATION	
	eSERVICES	EMAIL
Change in address or telephone number of any service	Yes	Yes
Addition or departure of any professional staff	Yes	Yes
Change in linguistic capability, specialty, or program	Yes	Yes
Discontinuation of any covered services listed in Exhibit A of provider's PSA	Yes	Yes
Change in licensure or accreditation of provider or any of its professional staff	Yes	Yes
Appointment Access		
Change in licensure or accreditation of provider or any of its professional staff	Yes (license)	Yes
Change in hours of operation	Yes	Yes
Is no longer accepting new patients	Yes	Yes
Is available during limited hours or only in certain settings	Yes	Yes
Has any other restrictions on treating members	Yes	Yes
Is temporarily or permanently unable to meet Beacon standards for appointment access	Yes	Yes
Other		
Change in designated account administrator for the provider's eServices accounts	No	Yes
Merger, change in ownership, or change of tax ID number (as specified in the PSA, Beacon is not required to accept assignment of the PSA to another entity)	No	Yes
Adding a site, service, or program not previously included in the PSA, remember to specify:		
a. Location	No	Yes
b. Capabilities of the new site, service, or program		

5.4. Beacon Provider Database

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

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

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

5.5. Other Benefits Information

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

YOUR HEALTH PLAN MEMBER IDENTIFICATION CARDS

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

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

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

5.6. Member Eligibility Verification Tools

ONLINE	ELECTRONIC DATA INTERCHANGE (EDI)	VIA TELEPHONE
Beacon's (Amidacare, Affinity, MetroPlus) eServices	Providers with EDI capability can use the 270/271 EDI transaction with Beacon. To set up an EDI connection, view the companion guide, then contact edi.operations@beaconhealthoptions.com	888.210.2018 Beacon's Integrated Voice Recognition (IVR)
Former ValueOptions (Emblem and VNSNY)	Providers with EDI capability can use ProviderConnect. For more information, refer to https://www.beaconhealthoptions.com/providers/beacon/important-tools/e-commerce-initiative/ or contact the EDI Help Desk at e-supportservices@valueoptions.com	888.247.9311 from 8 am – 6 pm EST

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

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

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

5.7. Provider Training

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

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

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

C h a p t e r 6

Utilization and Care Management

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- 6.1. Utilization Management
 - 6.2. Medical Necessity and Level of Care Criteria
 - 6.3. Terms and Definitions
 - 6.4. Accessibility Standards
 - 6.5. Utilization Management Review Requirements
 - 6.6. Care Management
-

6.1. Utilization Management

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

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

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

6.2. Medical Necessity and Level of Care Criteria

Medical necessity is defined as health care and services that are necessary to prevent, diagnose, manage or treat conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap. For children and youth, medically necessary means health care and services that are necessary to promote normal growth and development and prevent, diagnose, treat, ameliorate or palliate the effects of a physical, mental, behavioral, genetic, or congenital condition, injury, or disability. Beacon shall perform utilization review (UR) for the determination of clinical appropriateness, level of care (LOC) and/or medical necessity to authorize payment for behavioral health services in the areas of mental health and substance use disorders. Beacon defines medically necessary services as those which are:

- A. Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (most current version of ICD or DSM) that threatens life, causes pain or suffering, or results in illness or infirmity
- B. Expected to improve an individual's condition or level of functioning
- C. Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs
- D. Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications
- E. Reflective of a level of service that is safe, where no equally effective, more conservative, and less resource intensive treatment is available
- F. Not primarily intended for the convenience of the recipient, caretaker, or provider
- G. No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency
- H. Not a substitute for non-treatment services addressing environmental factors

To ensure that members receive the care that best meets their individual behavioral health needs in the most appropriate treatment setting, members' needs are assessed and matched with the capabilities, locations and competencies of the provider network when authorizing services. All decisions regarding

authorization are made as expeditiously as the case requires, but no longer than required timeliness standards. Beacon's application of LOC criteria and authorization procedures represent a set of formal techniques designed to monitor the use of, and/or evaluate the medical necessity, appropriateness, efficacy, and efficiency of, behavioral health care services.

Beacon's Medical Necessity Criteria (MNC) are reviewed and updated at least annually and as needed when new treatment applications and technologies are adopted as generally accepted medical practice. Beacon's Corporate Medical Management Committee (CMMC) adopts, reviews, revises and approves Medical Necessity Criteria per client and regulatory requirements.

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

1. 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>).
2. Change Healthcare's InterQual Behavioral Health Criteria
3. American Society of Addiction Medicine (ASAM) Criteria
4. Custom criteria, including state or client specific levels of care as well as MCG Health Behavioral Health Care Criteria (formerly known as Milliman Care Guidelines) when contracted
5. Beacon's National Medical Necessity Criteria

All of Beacon's Medical Necessity criteria are objective and based on scientific medical/clinical evidence.

Sources such as the following are used in the development, review, and revision of criteria sets:

1. General databases (e.g., PubMed, Cochrane Library, etc)
2. Specialty guidelines (e.g.; American Society of Addiction Medicine, Substance Abuse and Mental Health Services Administration, American Academy of Child and Adolescent Psychiatry; American Psychiatric Association, American Psychological Association, the Centers for Medicare & Medicaid Services, The Association of Ambulatory Behavioral Healthcare, The Centers for Medicare & Medicaid Services, etc.) ,
3. Accreditation organizations' guidelines (e.g.; URAC, NCQA and the Joint Commission, etc.), and
4. National guidelines (e.g.; CDC, NIH, U.K.'s National Institute for Clinical Evidence, National Institute of Alcohol Abuse and Alcoholism, National Institute on Drug Abuse etc.)

Also, actively practicing medical professionals/ subject matter experts are involved in developing, adopting, and reviewing criteria.

Reference materials and decision trees are maintained and are available to clinical and medical team.

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

- In Attachment 2 of this provider manual

- Online, via eServices at www.beaconhealthoptions.com
- Telephonically – Callers are assisted by Member Services to have LOC criteria sent either electronically or by hard copy.
- The LOCADTR tool is available online at <https://extapps.oasas.ny.gov>

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

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

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

Beacon does not require a primary care physician (PCP) referral to obtain authorization for behavioral health services. A member may self-refer for specialist services except for ACT, inpatient psychiatric treatment, partial hospitalization and HCBS. A member may initiate outpatient behavioral health services for a predetermined number of visits, without prior authorization from Beacon, as determined by NYS OMH and OASAS. Authorization is required for ongoing outpatient services after members exceed the predetermined number of visits allowed by their health plan/State.

Beacon will cover emergency services for all members whether the emergency services are provided by an affiliated or non-affiliated provider. Beacon does not impose any requirements for prior approval of emergency services. CPEP, crisis intervention and OMH/OASAS specific non-urgent ambulatory services.

For substance use disorder facilities in NYS in-network, OASAS licensed providers, inpatient and residential services require notification of admission within two business days from admission. The decision to provide treatment or service to a member is the responsibility of the attending provider and the member (his or her patient).

Effective January 1, 2017, New York State OASAS licensed in-network providers must provide official "Notice of Admission" (NOA) for all Substance Use Disorder Services. This notification allows a provider to treat a member for a standardized amount of time, or until their discharge (whichever occurs first), without a preservice or concurrent medical necessity review. Beacon may request a medical necessity review upon discharge or after the standardized amount of time (whichever occurs first). Per NYSUD legislation, the member will be held harmless.

As of January, 1 2020 the legislation has been expanded to allow the first 28 calendar days of treatment services (not to exceed 28 treatment days) to be covered upon notification of admission, provided the notification was received within 2 business days of admission.

The process applies to members covered by Child Health Plus, Commercial, Essential, and Medicaid Managed Care plans.

Out-of-network providers and notifications received later than 2 business days will follow standard UM processes.

The NYSLOCATDR 3.0 tool will be used for level of care determination for OASAS services. The LOCADTR tool is available online at <https://extapps.oasas.ny.gov>

On January 1, 2020 New York State regulatory requirements changed for behavioral health utilization review. This legislation prohibits prior authorization of inpatient mental health services delivered by an in-network, Office of Mental Health (OMH) licensed facility to members under the age of 18.

Beacon implemented a Mental Health Notice of Admission (NOA) on all Health Plan and City of New York business. The NOA process will be available for all in network New York providers who complete the notification within two business days of admitting a member to one of the levels of care noted. Upon notification, providers will receive authorization as follows:

- For adults (18 years old and over):
 - IOP: 15 business days
 - PHP: 10 business days
 - Inpatient Mental Health: 9 calendar days
- For Children (17 years old and under)
 - IOP/PHP: 14 business days
 - Inpatient Mental Health: 14 calendar days

In-network, New York providers who do not complete the notification within 2 business days of a member admission, as well as out-of-network providers will be subject to the standard telephonic review process. The number of days initially allowed under the NOA were determined based on current average length of stay benchmarks across New York State for their respective levels of care. Although the services continue to be subject to medical necessity, review can only occur retrospectively after discharge (or after the initial authorization time period has passed, whichever comes first), and/or concurrently after the initial authorization time period.

Effective 10/01/21 to ensure clinically appropriate and parity compliant coverage, as well as provide additional discharge planning and care management support. Providers are required to notify Beacon of admission within two (2) business days via the NOA process; providers who do not complete the notification within two (2) business days of a member admission will be subject to the standard telephonic review process. Beacon will only conduct utilization review for acute services (inpatient or partial hospital programs) for members who meet the following clinical criteria:

- Individuals subject to a current Assisted Outpatient Treatment (AOT) court order
- Individuals who had an AOT court order that expired within the past five years
- Individuals with high utilization of inpatient or emergency department (ED) services in the past year as evidence by:
 - Three (3) or more psychiatric inpatient hospitalizations in the prior 12 months; OR
 - Four (4) or more psychiatric ED visits in the prior 12 months; OR
 - Three (3) or more medical inpatient hospitalizations in prior 12-months;
- Individuals who are readmitted to any mental health inpatient unit within thirty days of discharge from a prior mental health inpatient admission; or
- Individuals not meeting any of the above triggers whose length of stay exceeds 30 days. In these cases, Beacon will apply concurrent review from Day 31 onwards but will not apply medical necessity criteria or issue denials for any of the first 30 days.

This update only applies to mental health services; PHP, MH Residential, and Inpatient (not Obs) level of care are affected and to any provider in New York State both INN and OON. Providers out of state are not affected and for them it is business as usual. No changes to lower levels of care. Utilization management processes for SUD remain unchanged. Changes apply to members of all ages, though 14 days still guaranteed for children admitting to an INN provider. Within two (2) business days, providers will be made aware of whether a member meets clinical criteria requiring medical necessity review. This process applies to members covered by Medicaid, Commercial, and Exchange lines of business, not Medicare.

Adverse determinations (denials) are never decided on the basis of pre-review or initial screening and are always made by a Beacon physician/psychologist advisor (PA). All adverse determinations are rendered by board-certified psychiatrists or a psychologist of the same or similar specialty as the services being denied. All inpatient substance use disorder adverse determinations and appeals are made by a physician certified in addiction psychiatry. All specialized care denials and appeals for children under the age of 21 are made by board certified child psychiatrists. Physicians review all denials for services for a medically fragile child and such determinations must take into consideration the needs of the family/caregiver. All Beacon PAs hold current and valid, unrestricted licenses. Treating providers may request reconsideration of an adverse determination from a clinical peer reviewer, which will be completed within one business day of the request. Unless excluded by state regulation, psychologist advisors may deny outpatient services, including psychological testing, except when the requesting provider is a physician or a nurse prescriber; in those cases, a physician advisor must review and make a determination.

A written notice of an adverse determination will be sent to the member and provider and will include:

- a. The reasons for the determination including the clinical rationale, if any
- b. Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals
- c. Notice of the availability, upon request, of the member or the member's designee of the clinical review criteria relied upon to make such determination

The notice will also specify what, if any, additional necessary information must be provided to, or obtained by, the MCO in order to render a decision the appeal.

For Medicaid/FHP, notices will also include:

- a. A description of the action to be taken
- b. Statement that the MCO will not retaliate or take discriminatory action if an appeal is filed
- c. Process and timeframe for filing/reviewing appeals, including member rights to request an expedited review
- d. Member right to contact DOH, with 1-800 number, regarding their complaint
- e. Fair hearing notice including aid to continue rights
- f. Statement that the notice is available in other languages and formats for special needs and how to access these formats
- g. For Medicaid Advantage, offer of choice of Medicaid or Medicare appeal processes if service is determined by the MOC to be either Medicare or Medicaid, with notice that:
 - Medicare appeal must be filed 60 days from denial
 - Filing Medicare appeal means the member cannot file for a state fair hearing
 - The member may still file for Medicare appeal after filing for Medicaid appeal, if within the 60-day period

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

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

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

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

Beacon does not routinely request copies of medical records related to behavioral health treatment requests that are in prospective or concurrent review. Additional medical records will only be requested when there is difficulty in making a decision. Written authorization for release of health information is not required for routine healthcare delivery options. To avoid duplicative requests for information from members or providers, the original requestor of information will ensure all appropriate clinical and administrative staff receives the necessary clinical and demographic information. Practitioners/providers are required by the 2002 Standards for Privacy of Individually Identifiable Health Information (the Privacy Rule), to make a good-faith effort to obtain a patient's written acknowledgement of receipt of privacy rights and practices. Written consent for release of health information is not required for routine healthcare delivery options. When a provider is acting on behalf of a member, written consent from a member to release his/her record is preferred.

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

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

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

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

6.3. Terms and Definitions

UTILIZATION MANAGEMENT (UM)

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

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

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

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

ADVERSE ACTION/DETERMINATION

The following actions or inactions by the organization:

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

EMERGENCY SERVICES

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

Emergency medical condition means a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part
4. Serious disfigurement of a person

MEMBER

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

NON-URGENT (STANDARD) CONCURRENT REVIEW DECISIONS

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

NON-URGENT (STANDARD) PRE-SERVICE DECISIONS

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

PEER REVIEW CONVERSATION

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

POST-SERVICE REVIEW AND DECISIONS

Any review for care or services that have already been received. A post-service decision would authorize, modify or deny payment for a completed course of treatment where a pre-service decision was not rendered, based on the information that would have been available at the time of a pre service review and treatment stay, also known as retrospective decisions. Retrospective decisions are made within 30 days of receipt of necessary information.

Beacon may reverse a per-authorized treatment, service, or procedure based on a retrospective review pursuant to Section 4905(5) of PHL when:

- a. Relevant medical information presented to Beacon upon retrospective review is materially different from the information that was presented during the pre-authorization review
- b. The information existed at the time of the pre-authorization review but was withheld or not made available
- c. Beacon was not aware of the existence of the information at the time of the pre-authorization review
- d. Had they been aware of the information, the treatment, service, or procedure being requested would not have been authorized

URGENT CARE REQUESTS

Expedited and standard review timeframes for pre-authorization and concurrent review may be extended for an additional 14 days if:

- It could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment; or

- In the opinion of a practitioner with knowledge of the member's medical condition, it would subject the member to severe pain that cannot be adequately managed without the care or treatment that is requested
- Expedited review must be conducted when Beacon or requesting provider indicates that a delay would seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum functions. Members have the right to request expedited review, but Beacon may deny and notice will process under standard timeframes.

Failure of Beacon to make a UR determination within the time periods as prescribed is deemed to be an adverse determination subject to appeal. For Medicaid/FHP, Beacon will send notice of denial on the date review timeframes expire.

URGENT (EXPEDITED) CONCURRENT REVIEW DECISIONS

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

URGENT (EXPEDITED) PRE-SERVICE DECISIONS

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

Beacon does not require prior authorization for either urgent or non-urgent ambulatory services delivered by OASAS certified Part 822 outpatient clinics (including intensive outpatient services), outpatient rehabilitation and opioid treatment programs, OASAS certified Part 816 medically supervised outpatient withdrawal and stabilization programs

AUTHORIZATION NOTIFICATION EXPECTATIONS

For outpatient services, the member will be notified telephonically (in addition to a mailing) regarding the authorization determination of services. For all other levels of care (including 24-hour levels of care), the provider is delegated the responsibility to inform the member verbally of their authorization determination.

6.4. Accessibility Standards

For a table of Appointment Availability Standards by Service Type, see Table 2 in Attachment 1.

APPOINTMENT STANDARDS

TYPE OF APPOINTMENT/ SERVICE	APPOINTMENT ACCESS TIMEFRAMES AND EXPECTATIONS
General Appointment Standards	
Routine/Non-Urgent	Within 1 week

TYPE OF APPOINTMENT/ SERVICE	APPOINTMENT ACCESS TIMEFRAMES AND EXPECTATIONS
Urgent Care	Within 24 hours
Emergency Services	Immediately; 24 hours a day, 7 days per week

Children CFTSS and HCBS Specific Standards

Crisis Respite	Within 24 hours of request
Planned Respite	Within 1 week of request
Psychosocial Rehabilitation,	Urgent -within 72 hours of request; non-urgent- within 5 business days of request; pursuant to an emergency or hospital discharge or release from incarceration- within 72 hours of request
Community Psychiatric Support and Treatment	Urgent-within 24 hours; non-urgent-within 1 week of request; pursuant to an emergency or hospital discharge or release from incarceration- within 72 hours of request
Habilitation Services	Within 2 weeks of request
Caregiver/Family Supports and Services	Within 5 business days of request
Educational and Employment Support Services	Within two weeks of request
Peer Support Services	Within one week of request (unless appointment is pursuant to emergency or hospital discharge, in which case the standard is five days; or if services are needed urgently for symptom management, in which case the standard is 24 hours)

Aftercare Appointment Standards (*Inpatient and 24-hour diversionary services must schedule an aftercare follow-up prior to a member's discharge*)

Non-24-hour Diversionary	Within two calendar days
Psychopharmacology Services/ Medication Management	Within 14 calendar days

SERVICE AVAILABILITY

SERVICE AVAILABILITY	HOURS OF OPERATION
On-Call	<ul style="list-style-type: none">▪ 24-hour on-call services for all members in treatment▪ Ensure that all members in treatment are aware of how to contact the treating or covering provider after hours and during provider vacations
Crisis Intervention	<ul style="list-style-type: none">▪ Services must be available 24 hours per day, 7 days per week

SERVICE AVAILABILITY	HOURS OF OPERATION
	<ul style="list-style-type: none"> ▪ 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. For PCPs and OB/GYN providers, this includes providing access to a live voice for afterhours emergency consultation and care. If the provider uses an answering machine, the message must direct the member to a live voice. ▪ Providers are responsible for the crisis management of members in their care. Should a member in behavioral health crisis call Beacon (via the toll-free main number), the member will be connected with a clinician to address the crisis and ensure connection to crisis services. Following the intervention, Beacon will outreach to the provider to follow-up with the member and refer the member to care.
Outpatient Services	<ul style="list-style-type: none"> ▪ Outpatient providers should have services available Monday through Friday, from 8 a.m. to 5 p.m., ET at a minimum ▪ Evening and/or weekend hours should also be available at least two days per week
Interpreter Services	<ul style="list-style-type: none"> ▪ Under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency

For a table of Foster Care Initial Health Services, see Table 3 in Attachment 1.

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.

6.5. Utilization Management Review Requirements

INPATIENT AND DIVERSIONARY

In an effort to help providers that may be experiencing claims payment issues, Beacon runs quarterly reports identifying those providers that may benefit from outreach and education. Providers with low approval rates are contacted and offered support and documentation material to assist in reconciliation of

any billing issues that are having an adverse financial impact and ensure proper billing practices within Beacon's documented guidelines.

PRE-SERVICE REVIEW	CONTINUED STAY (CONCURRENT REVIEW)	POST-SERVICE REVIEW
<p>The facility clinician making the request needs the following information for a pre-service review:</p> <ul style="list-style-type: none"> ▪ Member's health plan identification number ▪ Member's name, gender, date of birth, and city or town of residence ▪ Admitting facility name and date of admission ▪ ICD or DSM diagnosis: (A provisional diagnosis is acceptable.) ▪ Description of precipitating event and current symptoms requiring inpatient psychiatric care ▪ Medication history ▪ Substance abuse history ▪ Prior hospitalizations and psychiatric treatment ▪ Member's and family's general medical and social history ▪ Recommended treatment plan relating to admitting symptoms and the member's anticipated response to treatment ▪ Recommended discharge plan following end of requested service 	<p>To conduct a continued stay review, call a Beacon UR clinician with the following required information:</p> <ul style="list-style-type: none"> ▪ Member's current diagnosis and treatment plan, including physician's orders, special procedures, and medications ▪ Description of the member's response to treatment since the last concurrent review ▪ Member's current mental status, discharge plan, and discharge criteria, including actions taken to implement the discharge plan ▪ Report of any medical care beyond routine is required for coordination of benefits with health plan (Routine medical care is included in the per diem rate.) 	<p>Post-service reviews may be conducted for inpatient, diversionary or outpatient services rendered when necessary. To initiate a post-service review, call Beacon. If the treatment rendered meets criteria for a post-service review, the UR clinician will request clinical information from the provider, including documentation of presenting symptoms and treatment plan via the member's medical record. Beacon requires only those section(s) of the medical record needed to evaluate medical necessity and appropriateness of the admission, extension of stay, and the frequency or duration of service. A Beacon physician or psychologist advisor completes a clinical review of all available information, in order to render a decision.</p>

Authorization determination is based on the clinical information available at the time the care was provided to the member.

For a grid showing Authorization Requirements for Benefits and Medicaid State Plan and Demonstration Benefits for all Medicaid Managed Care Population under age 21, see Table 1 in Attachment 1.

NEW YORK AMBULATORY BEHAVIORAL HEALTH SERVICES AUTHORIZATION RULES

The NYS OMH and OASAS has issued guidance on authorization rules for ambulatory behavioral health services for adults. Below are the authorization guidance and expectations for timely appointments for behavioral health services within Mainstream Managed Care, HIV Medicaid SNP, and Health and Recovery Plans cover. Following an emergency, hospital discharge or release from incarceration, if known, follow up visits with a behavioral health participating provider should be offered within a minimum of five days of request or as clinically indicated.

Members may also self-refer for at least OB/GYN care: prenatal care, two routine visits per year and any follow-up care, acute gynecological condition. For Medicaid/FHP, they may also self-refer for:

- At least one mental health visit and one substance abuse visit with a participating provider per year for evaluation. (Note: Beacon allows members to self-refer to all outpatient behavioral health services)
- Vision services with a participating provider
- Diagnosis and treatment of TB by public health agency facilities
- Family planning and reproductive health from participating provider or Medicaid provider

SERVICE	PRIOR AUTHORIZATION	CONCURRENT REVIEW	ADDITIONAL GUIDANCE
Outpatient mental health office and clinic services including: initial assessment; psychiatric assessment; psychosocial assessment; medication treatment; and individual, family/collateral, and group psychotherapy	No	Yes	MMCOs/HARPs must pay for at least 30 visits per treatment episode without requiring authorization. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law. Non-urgent appointments should be offered within two to four weeks of request.
Psychological or neuropsychological testing	Yes	N/A	Non-urgent appointments should be offered within two to four weeks of request.
Personalized Recovery Oriented Services (PROS) Pre-Admission Status	No	No	Begins with initial visit and ends when Initial Service Recommendation (ISR) is submitted to Plan. Providers bill the monthly Pre-Admission rate

SERVICE	PRIOR AUTHORIZATION	CONCURRENT REVIEW	ADDITIONAL GUIDANCE
			but add-ons are not allowed. Pre-Admission is open-ended with no time limit. Appointment should be given within 24 hours of request.
Personalized Recovery Oriented Services (PROS) Admission: Individualized Recovery Planning	Yes	Yes	Begins when IRP is approved by Plan. Concurrent review and authorizations should occur at three-month intervals for IR and ORS services and at six-month intervals for Base/Community Rehabilitation and Support (CRS) and Clinic Treatment services. Appointments should be offered within two weeks of request.
Mental Health Continuing Day Treatment (CDT)	Yes	Yes	Appointment should be offered within two to four weeks of request
Mental Health Intensive Outpatient (note: NOT State Plan)	Yes	Yes	Appointment should be offered within one week of request
Mental Health Partial Hospitalization	Yes	Yes	
Assertive Community Treatment (ACT)	Yes	Yes	New ACT referrals must be made within 24 hours and should be made through local Single Point Of Access (SPOA) agencies. Plans will collaborate with SPOA agencies around determinations of eligibility and appropriateness for ACT.
Outpatient Office and Clinic Services provided by OASAS-certified agencies including: initial assessment; psychiatric assessment; psychosocial assessment;	No	Yes	LOCADTR tool to inform level of care determinations. Appointments should be offered within 24 hours of request.

SERVICE	PRIOR AUTHORIZATION	CONCURRENT REVIEW	ADDITIONAL GUIDANCE
medication treatment; and individual, family/collateral, and group psychotherapy			
Medically Supervised Outpatient Substance Withdrawal	No	No	LOCADTR tool to inform level of care determinations. Appointments should be offered within 24 hours of request.
Opioid Treatment Program (OTP) Services	No	Yes	LOCADTR tool to inform level of care determinations. Appointments should be offered within 24 hours of request.
Substance Use Disorder Intensive Outpatient	No	Yes	LOCADTR tool to inform level of care determinations. Appointments should be offered within one week of request.
Substance Use Disorder Day Rehabilitation	No	Yes	LOCADTR tool to inform level of care determinations. Appointments should be offered within two to four weeks of request.
Stabilization and Rehabilitation services for residential SUD treatment	Yes	Yes	LOCADTR tool to inform level of care determinations. Appointments should be offered within 24 hours of request.

If a service is not a covered benefit, providers are expected to advise the member prior to initiating the services to state the cost of the service.

OUT-OF-NETWORK EXCEPTIONS

Providers must be in-network with Beacon to request authorization (when applicable) and be reimbursed. However, some exceptions are reviewed on a case-by-case basis, including:

- Member cannot access a provider with the appropriate specialty required to treat the presenting issue
- Member cannot access an in-network covered service provider due to geographic limitations

- Transition of care needs up to a period of 90 days

Providers must agree to:

- Continue to accept reimbursement at rates applicable prior to transitional care
- Adhere to the organization's quality assurance program and provide medical information related to the member's care
- Adhere to Beacon's policies and procedures including referrals and obtaining pre-authorization and a treatment plan approved by the organization.

Providers with a request for authorization for out-of-network exceptions, regardless of rationale, should contact Beacon directly by telephone to request an out-of-network authorization.

EMERGENCY PRESCRIPTION SUPPLY

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

For prescribers, a 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization is not available. This applies to all drugs requiring a prior authorization, either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

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

REQUEST FOR RECONSIDERATION OF ADVERSE DETERMINATION

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

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

CLINICAL APPEALS PROCESS

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

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

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

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

Unless otherwise provided for in the member benefit plan, government sponsored health benefit program, or applicable state or federal law or regulation, the provider/participating provider and/or the member (or the member's authorized representative), has the right to file or request an appeal of an adverse determination up to 60 business days from the date of the initial adverse action notice. An appeal may be made verbally, in writing, or via fax transmission.

Appeal policies are made available to members and/or their appeal representatives upon request. Appeal rights are included in all action/adverse determination notifications. Every appeal receives fair consideration and timely determination by a Beacon employee who is a qualified professional. Beacon conducts a thorough investigation of the circumstances and determination being appealed, including fair consideration of all available documents, records, and other information without regard to whether such information was submitted or considered in the initial determination. The member, member's authorized representative, and/or the provider/participating provider may submit any information they feel is pertinent to the appeal request and all such information is considered in the appeal review. Punitive action is never taken against a provider who requests an appeal or who supports a member's request for an appeal.

The date of the request for an appeal of the adverse action is considered the date and time the appeal request is received by Beacon.

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

Peer Review

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

Urgency of Appeal Processing

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

Appeals Process Detail

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

1. Expedited Clinical Appeals

2. Standard Clinical Appeals

Each table illustrates:

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

EXPEDITED CLINICAL APPEALS

LEVEL 1 APPEAL	LEVEL 2 APPEAL	EXTERNAL REVIEW
<p>Medicaid Members, their legal guardians, or their authorized representatives have up to 60 business days from the date of the adverse action notice to file an appeal.</p> <p>If the member designates an authorized representative to act on his or her behalf, Beacon will attempt to obtain a signed and dated <i>Authorization of Representative Form</i>. Both verbal and written communication can take place with a provider who initiated the expedited appeal or with the individual who the member verbally designated as his or her representative.</p> <p>A Beacon PA, who has not been involved in the initial decision, reviews all available information and attempts to speak with the member's attending physician.</p> <p>An appeal determination for inpatient substance use disorder treatment is made within 24 hours if the request is received at least 24 hours before the member leaves the hospital.</p> <p>A decision is made within three business days of receipt of the request. Verbal notification to requesting provider occurs</p>	<p>Member appeal rights are limited to those available under the member's benefit plan, and may involve one or more levels of appeal.</p> <p>Expedited appeals not resolved to the satisfaction of the member, their legal guardian, or their authorized representative may be re-appealed via the standard appeal process, when available, or through the external appeal process.</p> <p>Members do not have to complete an internal Level 2 appeal to request an external appeal.</p>	<p>Medicaid Members or their representatives may request an expedited State Fair Hearing with the state office associated with the member's Medicaid plan. Please refer to the health plan-specific contact information at the end of this manual for the address and phone number of the State Fair Hearing office.</p> <p>For assistance in filing a request for a State Fair Hearing with the state office associated with the member's Medicaid plan, members or their representatives may contact Beacon's Member Services Department through the plan's dedicated phone line. Please refer to the health plan-specific contact information at the end of this manual.</p> <p>Please note: members may represent themselves or appoint someone to represent them at the fair hearing.</p> <p>Independent External Reviews with a state appointed agency are available only in cases where the health care services were:</p> <ul style="list-style-type: none"> ▪ Not medically necessary ▪ Experimental/ investigational

EXPEDITED CLINICAL APPEALS

LEVEL 1 APPEAL	LEVEL 2 APPEAL	EXTERNAL REVIEW
<p>within the decision timeframe. Written notification of the decision is sent to the provider and the member within two business days of the determination.</p> <p>In the event that an expedited request is not granted because the case does not meet expedited criteria, the member will receive prompt verbal notification and also written notification that the request will be processed within the standard timeframes.</p> <p>Throughout the course of an appeal, the member shall continue to receive services without liability for services previously authorized by Beacon, as long as all of the following criteria are met:</p> <ul style="list-style-type: none"> ▪ The appeal was filed in a timely fashion ▪ The appeal involved the termination, suspension, or reduction of a previously authorized course of treatment ▪ The services were ordered by an authorized provider ▪ The original period covered by the authorization has not expired ▪ The member requested an extension of the benefits 		<ul style="list-style-type: none"> ▪ Not different from care you can get in the plan's network ▪ Available from a participating provider who has the correct training and experience to meet your needs <p>Before requesting an external review, members must file an internal appeal with Beacon and get a final adverse determination. If an Internal expedited appeal is requested with Beacon, the member may also request an expedited external review at the same time.</p> <p>The member and Beacon may jointly agree to skip the internal appeal process and the member may go directly to the external review and will provide written notice within 24 hours to the member regarding filing an external appeal Members or their representatives have 4 months to request an external review from receipt of a final adverse determination, or from when an agreement was made to skip Beacon's internal appeal process.</p>

STANDARD CLINICAL APPEALS

LEVEL 1 APPEAL	LEVEL 2 APPEAL	EXTERNAL REVIEW
<p>Medicaid Members, their legal guardians, or their authorized representatives have up to 60 business days from the date of the adverse action notice to file an appeal.</p> <p>Written appeal acknowledgment is sent within 15 calendar days of receipt of the request. If the member designates an authorized representative to act on his or her behalf, Beacon will attempt to obtain a signed and dated <i>Authorization of Representative Form</i>.</p> <p>Both verbal and written communication can take place with a provider who initiated the appeal or with the individual who the member verbally designated as his or her representative.</p> <p>Verbal appeals must be followed up by written signed appeal.</p> <p>A Beacon PA, who has not been involved in the initial decision, reviews all available information.</p> <p>A decision is made within 30 calendar days of request. Verbal notification occurs within decision timeframe and written notification is sent within two business days of the determination.</p> <p>If the appeal requires review of medical records, the member's or the authorized representative's signature is required on an <i>Authorization to Release Medical Information Form</i> authorizing the release of</p>		<p>Providers appealing on their own behalf must request an external review within 60 calendar days of the date of the adverse determination.</p> <p>Medicaid Members or their representatives have 60 calendar days from the date of an initial adverse action notice to request a state fair hearing.</p> <p>For assistance in filing a request for a State Fair Hearing with the state office associated with the member's Medicaid plan, members or their representatives may contact Beacon's Member Services Department through the plan's dedicated phone line. Please refer to the health plan-specific contact information at the end of this manual.</p> <p>Please note at the fair hearing, members may represent themselves or appoint someone to represent them.</p>

STANDARD CLINICAL APPEALS

LEVEL 1 APPEAL	LEVEL 2 APPEAL	EXTERNAL REVIEW
<p>medical and treatment information relevant to the appeal.</p> <p>If it is determined relevant information to review the appeal is not received, a letter is sent within 15 days requesting additional information to complete the appeal request.</p> <p>If partial information is received another letter will be sent within five days requesting additional information.</p> <p>If the medical record with <i>Authorization to Release Medical Information Form</i> is not received prior to the deadline for resolving the appeal, a resolution will be rendered based on the information available. The provider must submit the medical chart for review. If the chart is not received, a decision is based on available information.</p> <p>If the health care service requested is not very different from a health care service available from a participating provider, Beacon can review the request for medical necessity.</p> <p>The following information should be sent with the appeal request:</p> <ul style="list-style-type: none">▪ A statement in writing from the member's doctor that the out-of-network service is very different from the service the plan can provide from a participating provider. The doctor must be a board certified or board eligible		

STANDARD CLINICAL APPEALS

LEVEL 1 APPEAL	LEVEL 2 APPEAL	EXTERNAL REVIEW
<p>specialist who treats people who need the health care service being requested, such as:</p> <ul style="list-style-type: none">• A physician board certified in general psychiatry must review all inpatient level of care denials for psychiatric treatment• A physician certified in addiction treatment must review all inpatient level of care denials for SUD treatment▪ Two medical or scientific documents that prove the health care service being requested is more helpful to the member and will not cause more harm than the service the plan can provide from a participating provider. If the information is not sent with the appeal request, Beacon will review the appeal. However, the member may not be eligible for an external appeal. <p>An appeal may also be requested if the member thinks the participating provider does not have the correct training or experience to provide the health care service, and therefore, referral to an out-of-network provider is deemed medically necessary. The following information should be sent with the appeal request:</p> <ul style="list-style-type: none">▪ A statement in writing that says our participating		

STANDARD CLINICAL APPEALS

LEVEL 1 APPEAL	LEVEL 2 APPEAL	EXTERNAL REVIEW
<p>provider does not have the correct training and experience to meet the member's needs</p> <ul style="list-style-type: none"> ▪ Recommends an out-of-network provider with the correct training and experience who is able to provide the health care service. The member's doctor must be a board certified or board eligible specialist who treats people who need the health care service being requested. <p>Beacon will review the appeal to see if a referral to the out-of-network provider is medically necessary. If the information is not sent, Beacon will review the appeal. However, the member may not be eligible for an external appeal.</p> <p>Decision timeframes for the resolution of an appeal can be extended by 14 days if the member or his/her representative requests an extension, or Beacon can demonstrate additional information is necessary and is in the best interest of the member.</p>		
<p>Contact Information</p> <p>Appeal requests can be made by calling or writing to Beacon's Appeals Department. Please refer to the health plan-specific addendum for contact information.</p>	<p>Contact Information</p> <p>Appeal requests can be made by calling or writing to Beacon's Appeals Department. Please refer to the health plan-specific addendum for contact information.</p>	<p>Contact Information</p> <p>For external appeal application and instructions, Medicaid members or their representatives may:</p> <ul style="list-style-type: none"> ▪ Call Beacon

STANDARD CLINICAL APPEALS

LEVEL 1 APPEAL	LEVEL 2 APPEAL	EXTERNAL REVIEW
		<ul style="list-style-type: none">▪ Call the New York State Department of Financial Services at 800.400.8882▪ Go online: www.dfs.ny.gov <p>For Medicaid Members, please refer to the health plan-specific contact information at the end of this manual for the address and phone number of the State Fair Hearing Office.</p>

Please note that providers may act as a member's authorized representative.

FINAL ADVERSE DETERMINATION

Written notice of final adverse determination concerning an expedited UR appeal shall be transmitted to member within 24 hours of the determination. For Medicaid/FHP Beacon will make reasonable effort to provide oral notice to member and provider at the time the determination is made.

Each notice of final adverse determination will be in writing, dated, and include:

- The basis and clinical rationale for the determination
- The words "final adverse determination"
- Contact person and phone number
- Enrollee coverage type
- Name and address of UR agent, contact person, and phone number
- Health service that was denied, including facility/provider and developer/manufacturer of service as available
- Statement that enrollee may be eligible for external appeal and timeframes for appeal
- If health plan offers two levels of appeal, cannot require enrollee to exhaust both levels. Must include clear statement in bold that enrollee has 45 days from the final adverse determination to request an external appeal and choosing 2nd level of internal appeal may cause time to file external appeal to expire.
- Standard description of external appeals process attached

For Medicaid/FHP, notice will also include:

- Summary of appeal and date filed
- Date appeal process was completed
- Description of enrollee's fair hearing rights if not included with initial denial

- Right of enrollee to complain to the Department of Health at any time with 1-800 number
- Statement that notice available in other languages and formats for special needs and how to access these formats.

Failure by Beacon to make a determination within the applicable time periods shall be deemed a reversal of the utilization review agent's adverse determination.

6.6. Care Management

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

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

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

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

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

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

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

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

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

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

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

Determinants of medical, behavioral, and/or social risk can include:

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

For more information on determining eligibility for Health Home services, see

http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_home_policy.htm

Quality Management and Improvement Program

- 7.1. Quality Management/Improvement Program Overview
 - 7.2. Provider Role
 - 7.3. Quality Monitoring
 - 7.4. Treatment Records
 - 7.5. Performance Standards and Measures
 - 7.6. Practice Guidelines and Evidence-Based Practices
 - 7.7. Outcomes Measurement
 - 7.8. Communication between Outpatient Behavioral Health Providers and PCPs, Other Treaters
 - 7.9. Communication between Inpatient/Diversionary Providers and PCPs, Other Outpatient Treaters
 - 7.10 Reportable Incidents and Events
 - 7.11 Provider Responsibilities
-

7.1. Quality Management/Improvement Program Overview

Beacon administers, on behalf of the partner health plan, a Quality Management and Improvement (QM & I) Program whose goal is to continually monitor and improve the quality and effectiveness of behavioral health services delivered to members. Beacon's QM & I Program integrates the principles of continuous quality improvement (CQI) throughout our organization and the provider network.

PROGRAM PRINCIPLES

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

PROGRAM GOALS AND OBJECTIVES

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

7.2. Provider Role

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

To participate in Beacon's Provider Advisory Council, email provider.relations@beaconhealthoptions.com. Members who wish to participate in the in an advisory capacity or in the Consumer Advisory Council should contact the Member Services Department.

7.3. Quality Monitoring

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

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

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

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

COMMITTEE STRUCTURE

In addition, Beacon and/or its health plan partners maintain committees, such as the Behavioral Health Quality Management Subcommittee (BHQM) and the Behavioral Health Utilization Management Subcommittee (BHUM) that provide oversight, guidance, and ongoing performance monitoring related to the populations, benefits and services under the children's standards. The committees meet on a quarterly basis and includes participation of members, family members, youth and family peer support and child serving providers in an advisory capacity, to inform the design and implementation of key quality, UM, and clinical initiatives.

The BHQM committee is accountable to and reports regularly to the governing board or its designee concerning behavioral health QM activities. It is responsible for carrying out the planned quality activities within the Children's Standards related to individuals with behavioral health conditions who access behavioral health benefits and/or HCBS. The committee is led by the BHQM Director, who also maintains records documenting attendance by members, as well as committee findings, recommendations, and actions. The BHQM committee documents committee activities (focused discussions, tracking, trending, analysis and follow-up) related to services for medically fragile children/complex conditions, and related to behavioral health services and HCBS for children.

The BH Medical Director for Children's Services participates on the BHUM subcommittee, which examines service utilization and outcomes for children including medically fragile children. It reviews and analyzes data in the following areas: Under- and over-utilization of behavioral health services and cost data; admission and readmission rates/trends; average length of stay; follow-up after discharge; inpatient and outpatient civil commitments; emergency department utilization and crisis services use; behavioral health prior authorizations/denials/notices of action; substance use disorder initiation and engagement rates; FEP initiation and engagement rates; psychotropic medication utilization (with separate analysis for

children in foster care); addiction medication utilization; transitional issues for youth ages 18 to 23 years, focusing on the continuity of care and service utilization; and other metrics as determined by the State.

For children eligible for HCBS, the UM BH subcommittee shall separately report, monitor and recommend appropriate action on: use of crisis diversion and crisis intervention services; prior authorizations/denials/notices of action; HCBS utilization; HCBS quality assurance performance measures as determined by the State and pending CMS requirements; and enrollment in Health Home.

Beacon and the Plans will ensure intervention have measurable outcomes and are included in BH UM committee meeting minutes. Analyses will be conducted separately for individuals under 21 years of age.

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

7.4. Treatment Records

TREATMENT RECORD REVIEWS

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

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

Beacon may conduct chart reviews onsite at a provider facility, or may ask a provider to copy and send specified sections of a member's medical record to Beacon. Any questions that a provider may have regarding Beacon access to the health plan member information should be directed to Beacon's privacy officer, elaine.stone@beaconhs.com.

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

TREATMENT RECORD STANDARDS

To ensure that the appropriate clinical information is maintained within the member's treatment record, providers must follow the documentation requirements below, based upon NCQA standards. All documentation must be clear and legible. At a minimum, medical records must be retained for a period of six years after the date of service rendered to members. For a minor, records must be retained for three years after they reach the age of majority or six years after the date of the service, whichever is later.

Member Identification Information

The treatment record contains the following member information:

- Member name and health plan identification # on every page

- Member's address
- Employer or school
- Home and work telephone number
- Marital/legal status
- Appropriate consent forms
- Guardianship information, if applicable

Informed Member Consent for Treatment

The treatment record contains signed consents for the following:

- Implementation of the proposed treatment plan
- Any prescribed medications
- Consent forms related to interagency communications
- Individual consent forms for release of information to the member's PCP and other behavioral health providers, if applicable; each release of information to a new party (other than Beacon or the health plan) requires its own signed consent form.
- Consent to release information to the payer or MCO (In doing so, the provider is communicating to the member that treatment progress and attendance will be shared with the payer.)
- For adolescents, ages 12–17, the treatment record contains consent to discuss substance abuse issues with their parents.
- Signed document indicating review of patient's rights and responsibilities

Medication Information

The treatment records contain medication logs clearly documenting the following:

- All medications prescribed
- Dosage of each medication
- Dates of initial prescriptions
- Information regarding allergies and adverse reactions are clearly noted.
- Lack of known allergies and sensitivities to substances are clearly noted.

Medical and Psychiatric History

The treatment record contains the member's medical and psychiatric history including:

- Previous dates of treatment
- Names of providers
- Therapeutic interventions
- Effectiveness of previous interventions
- Sources of clinical information

- Relevant family information
- Results of relevant laboratory tests
- Previous consultation and evaluation reports

Substance Abuse Information

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

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

Adolescent Depression Information

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

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

ADHD Information

Documentation for members aged 6-12 assessed for ADHD:

- Was family involved with treatment?
- Is there evidence of the member receiving psychopharmacological treatment?

Diagnostic Information

- Risk management issues (e.g., imminent risk of harm, suicidal ideation/intent, elopement potential) are prominently documented and updated according to provider procedures
- All relevant medical conditions are clearly documented, and updated as appropriate.
- Member's presenting problems and the psychological and social conditions that affect their medical and psychiatric status

A complete mental status evaluation is included in the treatment record, which documents the member's:

- a. Affect
- b. Speech
- c. Mood
- d. Thought control, including memory
- e. Judgment
- f. Insight
- g. Attention/concentration
- h. Impulse control
- i. Initial diagnostic evaluation and DSM diagnosis that is consistent with the stated presenting problems, history, mental status evaluation, and/or other relevant assessment information
- j. Diagnoses updated at least on a quarterly basis

Treatment Planning

The treatment record contains clear documentation of the following:

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

Treatment Documentation

The treatment record contains clear documentation of the following:

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

Coordination and Continuity of Care

The treatment record contains clear documentation of the following:

- Documentation of communication and coordination among behavioral health providers, primary care physicians, ancillary providers, and healthcare facilities. (See Behavioral Health – PCP Communication Protocol, and the Behavioral Health – PCP Communication Form)
- Dates of follow-up appointments, discharge plans and referrals to new providers

Additional Information for Outpatient Treatment Records

These elements are required for the outpatient medical record:

- Telephone intake/request for treatment
- Face sheet
- Termination and/or transfer summary, if applicable
- The following clinician information on every entry (e.g., progress notes, treatment notes, treatment plan, and updates) should include the following treating clinician information:
 - a. Clinician's name
 - b. Professional degree

- c. Licensure
- d. NPI or Beacon Identification number, if applicable
- e. Clinician signatures with dates

Additional Information for Inpatient and Diversionary Levels of Care

These elements are required for inpatient medical records:

- Referral information (ESP evaluation)
- Admission history and physical condition
- Admission evaluations
- Medication records
- Consultations
- Laboratory and X-ray reports
- Discharge summary and Discharge Review Form

Information for Children and Adolescents

A complete developmental history must include the following information:

- Physical, including immunizations
- Psychological
- Social
- Intellectual
- Academic
- Prenatal and perinatal events are noted.

7.5. Performance Standards and Measures

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

- Communication with PCPs and other providers treating shared members
- Availability of routine, urgent and emergent appointments

Beacon will collaborate with the Plan's compliance with State Medicaid guidance including managed care policy documents, relevant performance improvement specification documents or manuals, and policies governing prior authorization, concurrent or retrospective review". Beacon supports the Plan's incorporation of the following guidance:

- i. OMH Clinic Standards of Care:
www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html) Full document included below.

- ii. OASAS Clinical Guidance:
(<https://www.oasas.ny.gov/AdMed/recommend/recommendations.cfm>)
- iii. OHIP, Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care, April 2013
(https://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf)
- iv. OCFS Working Together: Health Services for Children/Youth in Foster Care Manual
(http://ocfs.ny.gov/main/sppd/health_services/manual.asp)
- v. OHIP Principles for Medically Fragile Children (Attachment G)

7.6. Practice Guidelines and Evidence-Based Practices

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

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

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

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

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

1. Annually, three CPGs are selected for monitoring of practitioner/provider adherence and compliance. One of the three CPGs selected must address children and adolescents.
 - a. For each CPG selected, there are two or more important aspects of care selected for monitoring.
 - b. The annual assessment of practitioner/provider adherence includes but is not limited to chart reviews and claims data. This assessment may be population or practice based.
 - c. Results are measured annually through analysis of performance against the measures adopted. These results are used by Beacon to identify opportunities for improvement.
 - d. Interventions are implemented to improve practitioner/provider performance and to continually improve the quality of care provider to members.

The guidelines that Beacon promulgates include:

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

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

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

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

7.7. Outcomes Measurement

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

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

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

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

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

- Notice of commencement of outpatient treatment within four visits or two weeks, whichever occurs first

- Updates at least quarterly during the course of treatment
- Notice of initiation and any subsequent modification of psychotropic medications
- Notice of treatment termination within two weeks

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

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

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

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

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

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

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

- Date of discharge
- Diagnosis

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

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

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

TRANSITIONING MEMBERS FROM ONE BEHAVIORAL HEALTH PROVIDER TO ANOTHER

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

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

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

If an enrolled child in foster care is placed in another county, and the Plan continues to cover the benefit in the new county, Beacon ensures that the child transitions to a new primary care provider and other healthcare providers without disrupting the care plan that is in place.

If an enrolled child in foster care is placed outside of the Plan's service area, Beacon ensures that the enrollee will access providers with expertise treating children involved in foster care as necessary to ensure continuity of care and the provision of all medically necessary benefit packages services.

7.10. Reportable Incidents and Events

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

ADVERSE INCIDENTS

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

SENTINEL EVENTS

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

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

OTHER REPORTABLE INCIDENTS

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

1. Non-medicolegal deaths
2. Suicide attempt at a behavioral health facility not requiring medical admission
3. Any absence without authorization from a facility involving a member who does not meet the criteria for a sentinel event as described above
4. Any physical assault or alleged physical assault by or against a member that does not meet the criteria of a sentinel event
5. Any serious injury while in a 24-hour program requiring medical treatment, but not hospitalization.
 - a. A serious injury is an injury that requires the individual to be transported to an acute care hospital for medical treatment and is not subsequently medically admitted.
6. Any unscheduled event that results in the temporary evacuation of a program or facility, such as a small fire that requires fire department response
7. Member fall unrelated to a physical altercation on a behavioral health unit
8. A medical event resulting in admission to a medical unit or facility

9. Any possession or use of contraband to include illegal or dangerous substances or tools (i.e., alcohol/drugs, weapons, or other non-permitted substances or tools)
10. Self-injurious behavior exhibited by a member while at a behavioral health facility
11. Illegal behavior exhibited by a member while at a behavioral health facility defined as illegal by state, federal or local law (i.e., selling illegal substances, prostitution, public nudity)

REPORTING METHOD

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

7.11. Provider Responsibilities

MEMBERS DISCHARGED FROM INPATIENT PSYCHIATRIC FACILITIES

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

Providers should be prepared to present:

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

PRIMARY CARE PROVIDERS

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

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

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

PCPs also inform member of their rights to:

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

UPDATES TO CONTACT INFORMATION

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

A t t a c h m e n t 1

Ambulatory Mental Health Services for Children

Table 1. Authorization Requirements for Benefits and Medicaid State Plan and Demonstration Benefits for all Medicaid Managed Care population under age 21

SERVICES	INITIAL AUTHORIZATION REQUIRED	CONCURRENT REVIEW REQUIRED	DELIVERY SYSTEM PRIOR TO 1/1/19
Assertive Community Treatment (minimum age is 18 for medical necessity for this adult-oriented service)	Yes	Yes	FFS
CFCO State Plan Services for Children Meeting Eligibility Criteria ¹	Will be managed by the health plan	Will be managed by the health plan	N/A
Children's Crisis Intervention (Former 1915(c) waiver service, transitioning to State Plan EPSDT Benefit)	No	No	FFS
Children's Day Treatment	Yes	Yes	FFS
Comprehensive Psychiatric Emergency Program (CPEP) including Extended Observation Bed	No	No	FFS (Current MMC Benefit for individuals age 21 and over)
Continuing Day Treatment (minimum age is 18 for medical necessity for this adult-oriented service)	Yes	Yes	FFS

¹ Beginning 1/1/19, eligibility for CFCO benefits will become available to children who are eligible for Medicaid solely because of receipt of HCBS (i.e., Family of One children who meet institutional admission criteria and receive HCBS). These children are not eligible for CFCO under the State Plan but will be eligible for identical benefits under the 1115 Demonstration Waiver Amendment.

SERVICES	INITIAL AUTHORIZATION REQUIRED	CONCURRENT REVIEW REQUIRED	DELIVERY SYSTEM PRIOR TO 1/1/19
Community Psychiatric Support and Treatment (CPST ²)	No	No	N/A (New State Plan service)
Crisis Intervention Demonstration Service	No	No	MMC Demonstration Benefit for all ages
Family Peer Support Services	No	No	FFS/1915(c) Children's waiver service
Health Home Care Management	Yes	Yes	FFS
Inpatient Psychiatric Services	Yes	Yes	Current MMC Benefit
Licensed Behavioral Health Practitioner (NP-LBHP) Service	No	No	MMC Demonstration Benefit for all ages
OMH and OASAS Licensed Outpatient Clinic Services	No	No	Current MMC Benefit

² NYS is exploring the use of EBPs. Pending CMS approval, these services will be billed through CPST and/or OLP, depending upon provider qualifications. Additional guidance will be issued regarding provider designation as well as the rate structure.

SERVICES	INITIAL AUTHORIZATION REQUIRED	CONCURRENT REVIEW REQUIRED	DELIVERY SYSTEM PRIOR TO 1/1/19
Medically Managed Detoxification (hospital-based)	Per NY legislation, if services are provided in NY and in-network, notification is required within 48 hours of admission for a 14-day registration. Authorization is required if out-of-state/out-of-network admission or lack of notification within 48 hours of admission.	Yes, after a 14-day registration period.	Current MMC Benefit
Medically Supervised Inpatient Detoxification	Per NY legislation, if services are provided in NY and in-network, notification is required within 48 hours of admission for a 14-day registration. Authorization is required if out-of-state/out-of-network admission or lack of notification within 48 hours of admission.	Yes, after a 14-day registration period.	Current MMC Benefit
Medically Supervised Outpatient Withdrawal	No	No	Current MMC Benefit

SERVICES	INITIAL AUTHORIZATION REQUIRED	CONCURRENT REVIEW REQUIRED	DELIVERY SYSTEM PRIOR TO 1/1/19
OASAS Inpatient Rehabilitation Services	Per NY legislation, if services are provided in NY and in-network, notification is required within 48 hours of admission for a 14-day registration. Authorization is required if out-of-state/out-of-network admission or lack of notification within 48 hours of admission.	Yes, after a 14-day registration period.	Current MMC Benefit
OASAS Opioid Treatment Program (OTP) Services	No	No	FFS ³
OASAS Outpatient and Residential Addiction Services	No	No	MMC Demonstration Benefit for all ages
OASAS Outpatient Rehabilitation Programs	No	No	FFS ⁴
OASAS Outpatient Services	No	No	FFS ⁵
OMH State Operated Inpatient	Yes	Yes	FFS

³For OASAS hospital-based programs.

⁴For OASAS hospital-based programs.

⁵For OASAS hospital-based programs.

SERVICES	INITIAL AUTHORIZATION REQUIRED	CONCURRENT REVIEW REQUIRED	DELIVERY SYSTEM PRIOR TO 1/1/19
Other Licensed Practitioner (OLP)	No	No	N/A (New State Plan Service)
Partial Hospitalization	Yes	Yes	FFS
Personalized Recovery Oriented Services (PROS) (minimum age is 18 for medical necessity for this adult-oriented service)	Yes	Yes	FFS
Psychosocial Rehabilitation (PSR)	No	No	N/A (New State Plan Service)
Rehabilitation Services for Residents of Community Residences	Yes	Yes	FFS
Residential Rehabilitation Services for Youth (RRSY)	Yes	Yes	FFS
Residential Supports and Services (New Early and Periodic Screening, Diagnostic and Treatment [EPSDT] Prevention, formerly known as foster care Medicaid Per Diem)	No	No	OCFS Foster Care
Residential Treatment Facility (RTF)	Yes	Yes	FFS
Teaching Family Home			FFS

SERVICES	INITIAL AUTHORIZATION REQUIRED	CONCURRENT REVIEW REQUIRED	DELIVERY SYSTEM PRIOR TO 1/1/19
Youth Peer Support and Training	No	No	FFS/1915(c) Children's waiver service

Table 2. Appointment Availability Standard by Service Type

SERVICE TYPE	EMERGENCY	URGENT	NON-URGENT	FOLLOW-UP TO EMERGENCY OR HOSPITAL DISCHARGE	FOLLOW-UP TO RESIDENTIAL SERVICES, DETENTION DISCHARGE, OR DISCHARGE FROM JUSTICE SYSTEM PLACEMENT
MH Outpatient Clinic		Within 24 hours	Within 1 week	Within 5 business days of request	Within 5 business days of request
Partial Hospitalization				Within 5 business days of request	
Inpatient Psychiatric Services	Upon presentation				
CPEP	Upon presentation				
OASAS Outpatient Clinic		Within 24 hours	Within 1 week of request	Within 5 business days of request	Within 5 business days of request
Detoxification	Upon presentation				
SUD Inpatient Rehab	Upon presentation	Within 24 hours			
OTP		Within 24 hours			
Crisis Intervention	Within 1 hour			Within 24 hours of Mobile Crisis Intervention response	

SERVICE TYPE	EMERGENCY	URGENT	NON-URGENT	FOLLOW-UP TO EMERGENCY OR HOSPITAL DISCHARGE	FOLLOW-UP TO RESIDENTIAL SERVICES, DETENTION DISCHARGE, OR DISCHARGE FROM JUSTICE SYSTEM PLACEMENT
CPST		Within 24 hours (for intensive in home and crisis response services under definition)	Within 1 week of request	Within 72 hours of discharge	Within 72 hours
OLP		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Family Peer Support Services		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Youth Peer Support and Training			Within 1 week of request	Within 72 hours of request	Within 72 hours of request
PSR		Within 72 hours of request	Within 5 business days of request	Within 72 hours of request	Within 72 hours of request
Caregiver/Family Supports and Services			Within 5 business days of request	Within 5 business days of request	Within 5 business days of request
Crisis Respite	Within 24 hours of request	Within 24 hours of request		Within 24 hours of request	

SERVICE TYPE	EMERGENCY	URGENT	NON-URGENT	FOLLOW-UP TO EMERGENCY OR HOSPITAL DISCHARGE	FOLLOW-UP TO RESIDENTIAL SERVICES, DETENTION DISCHARGE, OR DISCHARGE FROM JUSTICE SYSTEM PLACEMENT
Planned Respite			Within 1 week of request	Within 1 week of request	
Prevocational Services			Within 2 weeks of request		Within 2 weeks of request
Supported Employment			Within 2 weeks of request		Within 2 weeks of request
Community Self-Advocacy Training and Support			Within 5 business days of request		Within 5 business days of request
Habilitation			Within 2 weeks of request		
Adaptive and Assistive Equipment		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Accessibility Modifications		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Palliative Care			Within 2 weeks of request	Within 24 hours of request	

Table 3. Foster Care Initial Health Services Time Frames

TIME FRAME	ACTIVITY	MANDATED ACTIVITY	MANDATED TIME FRAME	WHO PERFORMS
24 Hours	Initial screening/ screening for abuse/ neglect	X	X	Health practitioner (preferred) or Child Welfare caseworker/ health staff
5 Days	Initial determination of capacity to consent for HIV risk assessment & testing	X	X	Child Welfare Caseworker or designated staff
5 Days	Initial HIV risk assessment for child without capacity to consent	X	X	Child Welfare Caseworker or designated staff
10 Days	Request consent for release of medical records & treatment	X	X	Child Welfare Caseworker or health staff
30 Days	Initial medical assessment	X	X	Health practitioner
30 Days	Initial dental assessment	X	X	Health practitioner
30 Days	Initial mental health assessment	X		Mental health practitioner
30 Days	Family Planning Education and Counseling and follow-up health care for youth age 12 and older (or younger as appropriate)	X	X	Health practitioner
30 Days	HIV risk assessment for child with possible capacity to consent	X	X	Child Welfare Caseworker or designated staff
30 Days	Arrange HIV testing for child with no possibility of capacity to consent & assessed to be at risk of HIV infection	X	X	Child Welfare Caseworker or health staff

TIME FRAME	ACTIVITY	MANDATED ACTIVITY	MANDATED TIME FRAME	WHO PER
45 Days	Initial developmental assessment	X		Health practitioner
45 Days	Initial substance abuse assessment			Health practitioner
60 Days	Follow-up health evaluation			Health practitioner
60 Days	Arrange HIV testing for child determined in follow-up assessment to be without capacity to consent & assessed to be at risk of HIV infection	X	X	Child Welfare C or health staff
60 Days	Arrange HIV testing for child with capacity to consent who has agreed in writing to consent to testing	X	X	Child Welfare C or health staff

A t t a c h m e n t 2

Beacon's New York Level of Care Criteria

New York Clinical 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.

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

- A.** Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (most current version of ICD or DSM,) that threatens life, causes pain or suffering, or results in illness or infirmity.
- B.** Expected to improve an individual's condition or level of functioning.
- C.** Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs.
- D.** Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.
- E.** Reflective of a level of service that is safe, where no equally effective, more conservative, and less resource intensive treatment is available.
- F.** Not primarily intended for the convenience of the recipient, caretaker, or provider.
- G.** No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
- H.** Not a substitute for non-treatment services addressing environmental factors.

Beacon uses clinical criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths, and treatment history in determining the best placement for a member. Beacon applies clinical

criteria to determine appropriate care for all members. In general, members will only be certified if they meet the specific medical necessity criteria for a particular level of care. However, the individual's needs and characteristics of the local service delivery system and social supports are taken into consideration.

Medical Necessity Criteria varies according to state and/or contractual requirements and member benefit coverage. In New York, Beacon uses five (5) sets of clinical criteria:

1. [Centers for Medicare and Medicaid \(CMS\) National Coverage Determination \(NCD\) and Local Coverage Determination\(LCD\) Criteria for Medicare members](#)
2. [New York State Office of Mental Health\(OMH\) Clinical Criteria for certain Medicaid services](#)
3. [Office of Addiction Support and Services \(OASAS\) Level of Care for Alcohol and Drug Treatment Referral \(LOCA DTR\) 3.0 for all lines of business \(excluding Medicare\) for providers located in New York](#)
4. [Change Healthcare's InterQual Behavioral Health Criteria for all mental health services in which CMS and OMH criteria is not applicable or available](#)
5. [American Society for Addiction Medicine \(ASAM\) Criteria for all Medicare members and for all other lines of business when the provider is located outside of New York State](#)

State Assurance

The state assures that rehabilitative services do not include and FFP is not available for any of the following in accordance with section 1905(a)(13) of the Act.

- Educational
- Room and board
- Habilitation services
- Service to inmates in public institutions as defined in 42 CFR435.1010;
- Services to individuals residing in institutions for mental disease as described in 42CFR435.1 010
- Recreational and social activities
- Services that must be covered elsewhere in the state Medicaid plan

Section 1: CMS Criteria

Overview

The Medicare Coverage Database (MCD) contains all NCD and LCD criteria. For all Medicare members first the relevant NCD or LCD criteria is identified when applying clinical criteria.

The following is a listing of services in which CMS NCD and LCD is utilized in New York:

- A** NCD Guideline 130.1 Inpatient Hospital Stay for Alcohol Detoxification
- B** NCD Guideline 130.2 Outpatient Services for Treatment of Alcohol
- C** NCD Guideline 130.5 Treatment of Alcoholism and Drug Abuse in a Freestanding Clinic
- D** NCD Guideline 130.6 Treatment of Drug Abuse(Chemical Dependency)
- E** NCD Guideline 130.7 Withdrawal Treatment for Narcotic Addictions
- F** LCD Guideline L33398 Transcranial Magnetic Stimulation (TMS)
- G** LCD Guideline L336245 Psychiatric Hospitalization
- H** LCD Guideline L33636 Psychiatric Partial Hospitalization Programs
- I** LCD Guideline L33632 Psychiatric and Psychiatry Services

Section 2: OMH Criteria

Overview

Beacon Health Options adopts the New York State Office of Mental Health (OMH) Clinical Criteria for use in rendering medical necessity determinations for certain services available to members enrolled in Medicaid Managed Care.

The following services utilize OMH clinical criteria when accessed by Medicaid Managed Care members:

- A** [Assertive Community Treatment\(ACT\)](#)
- B** [Personalized Recovery Oriented Services \(PROS\)](#)
- C** [Continuing Day Treatment\(CDT\)](#)
- D** [Intensive Psychiatric Rehabilitation Treatment Program \(IPRT\)](#)
- E** [Children and Family Treatment and Support Services \(CFTSS\)](#)
 - Other Licensed Practitioner(OLP)
 - Community Psychiatric Support and Treatment (CPST)
 - Psychosocial Rehabilitation (PSR)
 - Family Peer Support Services (FPSS)
 - Youth Peer Support and Training(Y PST)
 - Crisis Intervention (CI)
- F** [Home and Community Based Services –Adults](#)
 - Community Rehabilitation Services
 - Psychosocial Rehabilitation (PSR)
 - Community Psychiatric Support and Treatment (CPST)
- 6.** Vocational Services
 - Pre-vocational Services
 - Transitional Employment(TE)
 - Intensive Supported Employment (ISE)
 - Ongoing Supported Employment
- 7.** Short-Term Respite Services
 - Short-Term Crisis Respite
 - Intensive Crisis Respite
 - Education Support Services
 - Empowerment/Peer Support Services
 - Habilitation/Residential Support Services
 - Family Support and Training

G Home and Community Based Services –Children

- 14. Habilitation
- 15. Caregiver/Family Supports and Services
- 16. Respite
- 17. Pre-vocational Services
- 18. Supported Employment
- 19. Community Self-Advocacy Training and Supports
- 20. Non-Medical Transportation

Assertive Community Treatment (ACT)

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

Admission Criteria

All of the following criteria, 1-5, must be met; criteria 6 & 7 may also be met:

- 1) Severe and persistent mental illness (including, but not limited to diagnoses of schizophrenia, schizoaffective disorder, bipolar disorder and/or major or chronic depression), that seriously impairs their functioning in the community.
- 2) Recipients with serious functional impairments should demonstrate at least one of the following conditions:
 - a) Inability to consistently perform practical daily living tasks required for basic adult functioning in the community without significant support or assistance from others such as friends, family or relatives.
 - b) Inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role.
 - c) Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing).
- 3) Recipients with continuous high service needs should demonstrate one or more of the following conditions:
 - a) Inability to participate or succeed in traditional, office-based services or case management.
 - b) High use of acute psychiatric hospitals (two hospitalizations within one year, or one hospitalization of 60 days or more within one year).
 - c) High use of psychiatric emergency or crisis services.
 - d) Persistent severe major symptoms (e.g., affective psychotic, suicidal or significant impulse control issues).
 - e) Co-existing substance abuse disorder (duration greater than 6 months).
 - f) Current high risk or recent history of criminal justice involvement.
 - g) Court ordered pursuant to participate in Assisted Outpatient Treatment.
 - h) Inability to meet basic survival needs or homeless or at imminent risk of becoming homeless.
 - i) Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent setting if intensive community services are provided.
 - j) Currently living independently but clinically assessed to be at immediate risk of requiring a more restrictive living situation (e.g., community residence or psychiatric hospital) without intensive community services.
- 4) Member has been assessed and is not an immediate danger to self or others and does not require 24-hour medical supervision.
- 5) Member's condition is such that it can be expected to benefit and improve significantly through appropriate ACT interventions.

- 6) Member is stepping down from a higher level of care(LOC) and requires more intensive services than routine outpatient behavioral health treatment or other community based supports; and/or has past history of a similar clinical presentation where less intensive treatment was not sufficient to prevent clinical deterioration and the need for a higher LOC.
- 7) For children or adolescents, the parent or guardian agrees to participate in the member's treatment plan, as appropriate. Priority is given to individuals with SMI, individuals with continuous high service needs that are not being met in more traditional service settings, and individuals with ACT in their AOT order.

Exclusions

The following criteria is required for exclusion from this level of care:

1. Individuals with a primary diagnosis of a substance abuse disorder or mental retardation.
2. Members with a sole diagnosis of a personality disorder are not appropriate for ACT.
3. The member is not enrolled in HCBS services other than crisis residential services.

Continued Stay Criteria

All of the following criteria must be met:

- 1) Initial authorization criteria continue to be met.
- 2) A Comprehensive Assessment is completed within 30 days of admission, with specific objectives and planned services to achieve recovery goals.
- 3) Service plan is reviewed for progress and updated every 6 months, as necessary.
- 4) Continued coordination of care with other providers/stakeholders such as PCPs, specialty providers, inpatient treatment team, AOT, community supports, family, etc.
- 5) Active discharge planning is ongoing, with goal of transitioning the member to a less intensive LOC, when appropriate.

Discharge Criteria

ACT recipients meeting any one of the following criteria 1 , 2, 3, or 4 (criteria 5 & 6 are recommended, but optional) may be discharged:

- 1) Individuals who demonstrate, over a period of time, an ability to function in major life roles (ie work, social, self-care) and can continue to succeed with less intensive service.
- 2) Individuals who move outside the geographic area of the ACT team's responsibility, subsequent to the transfer of care to another ACT team or other appropriate provider and continued services until the member is engaged in care.
- 3) Individuals who need a medical nursing home placement, as determined by a physician.
- 4) Individuals who are hospitalized or locally incarcerated for three months or longer. However, an appropriate provision must be made for these individuals to return to the ACT program upon their release from the hospital or jail.
- 5) Individuals who request discharge, despite the team's best, repeated efforts to engage them in service planning. Special care must be taken in this situation to arrange alternative treatment when the recipient has a history of suicide, assault or forensic involvement.
- 6) Individuals who are lost to follow-up for a period of greater than 3 months after persistent efforts to locate them, including following all local policies and procedures related to reporting individuals as "missing persons", including, but, not limited to, conferring with Health Homes and MMCO/HARPs, to which Member maybe assigned.

Personalized Recovery Oriented Services (PROS)

PROS programs offer a customized array of recovery-oriented services, both in traditional program settings and in off-site locations where people live, learn, work or socialize. The purpose of PROS is to assist individuals in recovering from the disabling effects of mental illness through the coordinated delivery of rehabilitation, treatment and support services. Goals for members in the program may include, but are not limited to, improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education, and secure preferred housing. There are four service components, including Community Rehabilitation and Support (CRS), Intensive Rehabilitation (IR), Ongoing Rehabilitation and Support (ORS) and clinical treatment. Intensive Rehabilitation consists of four different services: 1) Intensive Rehabilitation Goal Acquisition, 2) Intensive Relapse Prevention, 3) Family Psychoeducation 4) Integrated Treatment for Dual Disorders. The minimum age for PROS is 18.

Admission Criteria

All of the following criteria, 1-11, must be met:

- 1) The member has a designated mental illness diagnosis.
- 2) The member must be 18 years of age or older.
- 3) The member must be recommended for admission by a Licensed Practitioner of the Healing Arts.
- 4) The member exhibits functional deficits related to the severity and duration of a psychiatric illness in any of the following areas: self-care, activities of daily living, interpersonal relations, and/or adaptation to change or task performance in work or work-like settings.
- 5) Pre-Admission begins with initial visit and ends when Initial Service Plan (ISR) is submitted to MMCO/HARP.
- 6) Admission begins when ISR is approved by MMCO/HARP.
- 7) Individualized Recovery Plan (IRP) must be developed within 60 days of admission date.
- 8) Active Rehabilitation begins when the Individualized Recovery Plan ("IRP") is approved by the MMCO/HARP and IRP indicates required services designed to engage and assist members in managing their illness and restoring those skills and supports necessary for living successful in the community.
- 9) The individual has developed or is interested in developing a recovery/life role goal.
- 10) There is not a lower level of care which is more appropriate to assist member with recovery goals.
- 11) A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services.

For Intensive Rehabilitation, any one of the following criteria (1-5), must be met:

1. Member has a specific goal related to education, housing or employment in which short term, intensive rehabilitation services would assist in achieving goal with desired timeframe.
2. The member is experiencing psychosocial stressors and/or difficulty in symptom management that has increased risk for hospitalization, involvement in criminal justice system, loss of housing, or other identified issues in which community tenure is at risk. Member would benefit from intensive rehabilitation and recovery services for relapse prevention.
3. Family psychoeducation would benefit member in achieving life role goal and maintaining community tenure.
4. Member has a co-occurring substance use disorder (including tobacco dependence) and would benefit from Integrated Treatment for Dual Disorders.
5. A member is not receiving Home and Community Services other than peer support services, education support

services and crisis residential services.

For Ongoing Rehabilitation and Support (ORS), any one of the following criteria, (1 -4), must be met:

1. Member has a specific goal related to competitive employment.
2. Member should be competitively employed and regularly scheduled for at least 10 hours of work per week with exceptions made for illness and vacation.
3. Member would benefit from support in managing their symptoms in a competitive workplace.
4. A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services.

Continued Stay Criteria

All of the following criteria, (1-3), must be met:

- 1)) The member continues to work towards goals, identified in an IRP.
- 2) Concurrent review and authorizations should occur at 3-month intervals for IR, ORS, and 6-month intervals for CRS and Clinic Treatment services. Continuing stay criteria may include:
 - a) The member has an active recovery goal and shows progress toward achieving it; OR
 - b) The member has met and is sustaining a recovery goal, but, would like to pursue a new goal; OR
 - c) The member requires a PROS level of care in order to maintain psychiatric stability and there is not a less restrictive level of care that is appropriate, or, without PROS services, the individual would require a higher level of care.
- 3) A member is not receiving Home and Community Services other than peer support services, education support services and crisis residential services.

For Intensive Rehabilitation and Ongoing Rehabilitation and Support, admission criteria continues to be met.

Discharge Criteria

Any one of the following criteria, (1-4), must be met:

1. The member has sustained recovery goals for 6-12 months and a lower level care is clinically indicated.
2. The member has achieved current recovery goals and can identify no other goals that would require additional PROS services.
3. The member is not participating in a recovery plan and is not making progress toward any goals. Extensive engagement efforts have been exhausted, and there is insignificant expected benefit from continued participation.
5. The member can live, learn, work and socialize in the community with supports from natural and/or community resources.

For Intensive Rehabilitation, any one of the criteria, 1-3, must be met:

1. The member is no longer at risk of hospitalization, involvement in criminal justice system and community tenure is assured in which intensive rehabilitation is no longer required.
2. The member has achieved current recovery goals and can identify no other goals that would require intensive rehabilitation.
3. The member can live, learn, work and socialize in the community with supports from natural and/or community

For Ongoing Rehabilitation and Support, any one of the following, (1 -3), must be met:

1. The member no longer requires supportive services for managing symptoms in the competitive workplace.
2. The member no longer is seeking competitive employment.
3. The member has achieved current recovery goals and can identify no other goals that would require ongoing rehabilitation and support.

Continuing Day Treatment (CDT)

Continuing Day treatment services assist individuals in beginning the recovery and rehabilitative process, providing supportive, transitional services to members that are no longer acutely ill, but still require moderate supervision to avoid risk and/or continue to re-integrate into the community or workforce. This structured, activity-based setting is ideal for members that continue to have significant residual symptoms requiring extended therapeutic interventions. Continuing Day treatment is focused on the development of a member's independent living skills, social skills, self-care, management of illness, life, work, and community participation, thus maintaining or enhancing current levels of functioning and skills. Members participating in treatment have access to crisis management, individual group, family therapy, and coordination with collateral contacts as clinically indicated. Treatment declines in intensity as members develop skills and attain specific goals within a reasonable timeframe allowing the transition to an outpatient setting with other necessary supports and longer-term supportive programming (i.e. clubhouse, employment, school, etc.). The minimum age for CDT is 18.

Admission Criteria

All of the following criteria, (1-7) must be met:

1. Symptoms consistent with a DSM or ICD diagnosis.
2. Member's exacerbation or long standing psychiatric disorder and level of functioning requires daily support and structure;
3. The member has the motivation and capacity to participate and benefit from day treatment.
4. Treatment at a less intensive level of care would contribute to an exacerbation of symptoms.
5. Member is assessed to be at risk of requiring a higher level of care if not engaged in day treatment services.
6. Member/guardian is willing to participate in treatment voluntarily.
7. Member's psychiatric/substance use/biomedical condition is sufficiently stable to be managed in a day treatment setting.

Exclusions

Any of the following criteria are sufficient for exclusion from this level of care:

1. The individual is a risk to self or others, or sufficient impairment exists that a more intensive level of service is required.
2. The individual can be safely maintained and effectively treated at a less-intensive level of care.
3. The individual does not voluntarily consent to admission or treatment, and/or refuses or is unable to participate in all aspects of treatment

4. The individual requires a level of structure and supervision beyond the scope of the program.
5. The individual has medical conditions or impairments that would prevent beneficial utilization of services.
6. The primary problem is social, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration

Continued Stay Criteria

All of the following criteria, (1-6), must be met:

1. Member continues to meet admission criteria.
2. Another less intensive level of care would not be adequate to administer care.
3. Treatment is still necessary to reduce symptoms and increase functioning for the member to be transitioned to a less restrictive setting.
4. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out.
5. Family/guardian is participating in treatment as clinically indicated.
6. Coordination of care and active discharge planning are ongoing.

Discharge Criteria

Any one of the following criteria, (1 -4), must be met; criteria (5 -6) recommended, but optional:

1. Member no longer meets admission criteria and/or meets criteria for another level of care either more or less intensive.
2. Member or guardian withdraws consent for treatment.
3. Member does not appear to be participating in the treatment plan.
4. Member is not making progress toward goals, nor is there expectation of any progress.
5. Member's individual treatment plan and goals have been met.
6. Member's support system is in agreement with the aftercare treatment plan.

Intensive Psychiatric Rehabilitation Treatment Program (IPRT)

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

Admission Criteria

All of the following criteria (1-4) must be met:

1. DSM or corresponding ICD diagnosis
2. Member has adequate capacity to participate in and benefit from this treatment.

3. Member has significant impairment in daily functioning due to a psychiatric illness or substance use of such intensity that the member cannot be managed in a lower level of care
4. Member is assessed to be at risk of requiring higher levels of care if not engaged in IPRT treatment.

Continued Stay Criteria

All of the following criteria (1 -2) must be met:

1. The member continues to meet admission criteria
- 2 One of the following is present:
 - a) The member has an active goal and shows progress toward achieving it.
 - b) The member has met and is sustaining a recovery goal, but would like to pursue a new goal related to a functional deficit in one of the above areas.
 - c) The member requires an IPRT level of care in order to maintain psychiatric stability;
 - d) There is not a less restrictive level of care that is appropriate or without IPRT services; and the individual would require a higher level of care.

Discharge Criteria

Any one of the following: Criteria (1, 2, 3, 4, 5, or 6):

1. The member no longer meets PRS level-of care criteria.
2. The member has sustained recovery goals for 3-6 months and a lower level of care is clinically indicated.
3. The member has achieved current recovery goals and can identify no other goals that would require additional I PRT services in order to achieve those goals.
4. The member is not participating in a recovery plan and is not making progress toward any goals.
5. Extensive engagement efforts have been exhausted and there is insignificant expected benefit from continued participation.
6. The member can live, learn, work and socialize in the community with supports from natural and/or community resources

Children's Family Treatment and Support Services (CFTSS)

CFTSS are new mental health and substance use services, available with NYS Children's Medicaid, that give children/ youth (under age 21) and their families the power to improve their health, well-being, and quality of life. These services strengthen families and help them make informed decisions about their care. Services are provided at home or in the community. There are six CFTSS:

1. Other Licensed Practitioner(OLP)
2. Psychosocial Rehabilitation (PSR)
3. Community Psychiatric Support & Treatment (CPST)
4. Family Peer Support Services (FPSS)

5. Youth Peer Support and Training(Y PST)
6. Crisis Intervention(CI)

Please refer to the "Children's Health and Behavioral Health Service Transformation –Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing(EPSDT) Services" for additional information regarding these services.

Other Licensed Practitioner (OLP)

OLP service is delivered by a Non-physician licensed behavioral health practitioner (NP-LBHP) who is licensed in the state of New York operating within the scope of practice defined in State Law and in any setting permissible under State practice law. OLP does not require a DSM diagnosis in order for the service to be delivered.

NP-LBHPs include individuals licensed and able to practice independently as a:

- Licensed Psychoanalyst
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist or
- Licensed Mental Health Counselor

An NP-LBHP also includes the following individual who are licensed under supervision or direction of a licensed Clinical Social Worker (LCSW), a Licensed Psychologist or a Psychiatrist:

- Licensed Master Social Worker(LMSW)

In addition to licensure service providers that offer addiction services must demonstrate competency as defined by state law and regulations. Any practitioner above must operate within a child serving agency that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS, OR DOH or its designee in settings permissible by that designation.

Admission Criteria

Either one of the following criteria, (1 or 2), must be met:

1. The child/youth is being assessed by the NP-LBHP to determine the need for treatment.
2. The NP-LBHP develops a treatment plan for goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits that:
 - a. Correct or ameliorates conditions that are found through an EPSDT screening; OR
 - b. Addresses the prevention, diagnosis, and/or treatment of health impairments; the ability to achieve age-appropriate growth and development, and the ability to attain, maintain, or regain functional capacity.

Continued Stay Criteria

Any one of the following criteria (1 or 2), and all of the criteria 3-6 must be met:

1. The child/youth is making some progress but has not fully reached established service goals and there is expectation that if the child/youth continues to improve, then the service continues OR
2. Continuation of the services is needed to prevent the loss of functional skills already achieved AND
3. The child/youth continues to meet admission criteria AND
4. The child/youth and/or family/caregiver(s) continue to engage in services AND

5. An alternative service(s) would not meet the child/youth needs AND
6. The treatment plan has been appropriately updated to establish or modify on going goals.

Discharge Criteria

Any one of the following criteria, (1 -6), must be met:

1. The child/youth no longer meets continued stay criteria OR
2. The child/youth has successfully reached individual/family established service goals for discharge; OR
3. The child/youth or parent/caregiver(s) withdraws consent for services; OR
4. The child/youth is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; or,
5. The child/youth is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR,
6. The child/youth and or family/caregiver(s) no longer needs OLP as he/she is obtaining a similar benefit through other services and resources.

OLP Limits and Exclusions

- Groups must not exceed more than 6-8 members. Consideration maybe given to a smaller limit of participants are younger than eight years of age
- Evidence Based Practice (EBPs) requires prior approval, designation, and fidelity reviews on an ongoing basis as determined necessary by New York State.
- Inpatient hospital facilities are allowed for licensed professionals other than social workers if a Preadmission screening and Resident Review (PASRR) indicates it is medically necessary treatment. Social worker visits are included in the Nursing Facility Visits and may not be billed separately.
- Visits to Intermediate Care Facilities for individual with Mental Retardation (ICF-MR) are not covered.
- All NP-LBHP services provided while the person is a resident of an institution for Mental Disease, such as a free standing psychiatric hospital psychiatric residential treatment facility, are part of the institutional service and not otherwise reimbursable by Medicaid
- If a child requires medical necessary service that are best delivered in the school setting by a community provider the service needs to be detailed on the treatment plan
- If a child needs assistance in the schools (educationally necessary) and a school employee will be providing the service, the service must be on the child's individualized Education Plan (IEP) (504 plan services are not reimbursable by Medicaid).
- Evidence based practice (EBP) requires approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State Treatment service must be a part of a treatment plan including goals and activities necessary to correct ameliorates conditions discovered during the initial assessment visits.

Psychosocial Rehabilitation (PSR)

Psychosocial Rehabilitation Services (PSR) are designed for children/youth and their families/caregivers to assist with implementing interventions outlined in the treatment plan to compensate for or eliminate functional deficits and interpersonal and/or behavioral health barriers associated with a child/youth's behavioral health needs. The intent of PSR is to restore, rehabilitate, and support a child/youth's functional level as possible as necessary for integration of the child/youth as an active and productive member of their community and family with minimal ongoing professional interventions. Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth's individualized treatment plan.

Admission Criteria

All of the following criteria, (1-4), must be met:

1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM; AND
2. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND
3. The service is needed to meet rehabilitative goals by restoring, rehabilitating, and/or supporting a child/youth's functional level to facilitate integration of the child/youth as participant of their community and family AND
4. The services are recommended by the following Licensed Practitioners of the Health Arts operating within the scope of their practice under State License:
 - Licensed Master Social Worker
 - Licensed Clinical Social Worker
 - Licensed Mental Health Counselor
 - Licensed Creative Arts Therapist
 - Licensed Marriage and Family Therapist
 - Licensed Psychoanalyst
 - Licensed Psychologist
 - Physician's Assistant
 - Psychiatrist
 - Physician
 - Registered Professional Nurse or
 - Nurse Practitioner

Continued Stay Criteria

All the following criteria, (1-5), must be met:

1. The child/youth continues to meet admission criteria; AND
2. The child/youth shows evidence of engagement towards resolution of symptoms but has not fully reached established service goals and there is expectation that if the service continues, the child/youth will continue to improve; AND
3. The child/youth does not require an alternative and/or higher, more intensive level of care or treatment; AND
4. The child/youth is at risk of losing skills gained if the service is not continued; AND
5. Treatment planning includes family/caregiver(s) and/or other support systems, unless clinically indicated or relevant

Discharge Criteria

Any one of the following criteria, (1 -6), must be met:

1. The child/youth no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive; OR
2. The child/youth has successfully met the specific goals outlined in the treatment plan for discharge; OR
3. The child/youth or parent/caregiver(s) withdraws consent for services; OR
4. The child/youth is not making progress or established service goals, nor is there expectation of any progress with continued provision of service; OR
5. The child/youth is no longer engaged in the services, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR
6. The child/youth and or family/caregiver(s) no longer needs this service as he/she is obtaining a similar benefit through other services and resources

PSR Limits/Exclusions

- The provider agency will assess the child prior to developing a treatment plan for the child.
- A licensed CPST practitioner or OLP must develop the treatment plan with the PSR worker implementing the intervention identified on the treatment plan
- A child with a development disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service
- Group should not exceed more than 6-8 members. Consideration maybe given to a smaller limit of members if participants are younger than eight years old
- Treatment service must be a part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.

Community Psychiatric Supports and Treatment (CPST)

CPST services are goal- directed supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve identified goals or objectives as set forth in the child/youth's treatment plan. This includes the implementation of interventions using evidenced based techniques drawn from cognitive behavioral therapy and/or other evidence based psychotherapeutic interventions approved by New York State.

CPST includes the following components: Rehabilitation Psychoeducation Intensive Interventions, Strength Based Treatment Planning, Rehabilitative Supports, Crisis Avoidance, and Intermediate Team Crisis Management

CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings but can benefit from community based rehabilitation services. CPST allows for delivery of services within a variety of permissible settings including community locations where the member lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes.

Admission Criteria

All of the following criteria, (1-4), must be met:

1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM OR the child/youth is at risk of development of a behavioral health diagnosis; AND

2. The child/youth is expected to achieve skill restoration in one of the following areas:
 - a) Participation in community activates and/or positive peer support networks
 - b) Personal relationships
 - c) Personal safety and/or self- regulation
 - d) Independence/productivity
 - e) Daily living skills
 - f) Symptom management
 - g) Coping strategies and effective functioning in the home, school, social or work environment; AND
3. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms, AND
4. The services are recommended by the following Licensed Practitioners of the Health Arts operating within the scope of their practice under State License:
 - Licensed Master Social Worker
 - Licensed Clinical Social Worker
 - Licensed Mental Health Counselor
 - Licensed Creative Arts Therapist
 - Licensed Marriage and Family Therapist
 - Licensed Psychoanalyst
 - Licensed Psychologist
 - Physician's Assistant
 - Psychiatrist
 - Physician
 - Registered Professional Nurse or
 - Nurse Practitioner

Continued Stay Criteria

All of the following criteria, (1-5), must be met:

1. The child/youth continues to meet admission criteria; AND
2. The child/youth shows evidence of engagement towards resolution of symptoms but has not fully reached established service goals and there is expectation that if the service continues the child/youth will continue to improve; AND
3. The child/youth does not require an alternative and/or higher, more intensive level of care or treatment; AND
4. The child/youth is at risk of losing skills gained if the service is not continued; AND
5. Treatment planning includes family/caregiver(s) and/or other support systems unless clinical indicated or relevant

Discharge Criteria

Any one of the following criteria, 1 -6, must be met:

1. The child/youth no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive; OR
2. The child/youth has successfully met the specific goals outlined in the treatment plan for discharge; OR 3) The child/youth or parent/caregiver(s) withdraws consent for services; OR

3. The child/youth is not making progression, established services goals, nor is there expectation of any progress with continued provision of services; OR
4. the child/youth is no longer engaged in services, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; Or,
5. The child/youth and/or family/caregiver(s) no longer needs this service as he/she is obtaining a similar benefit through other service and resources.

CPST Limits/Exclusions

- The provider agency will assess the child prior to developing a treatment plan for the child
- Treatment service must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visit
- A child with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative services
- Group face-to-face may occur for Rehabilitative Supports
 - Group should not exceed more than 6-8 members. Consideration maybe given to a smaller limit of members if participants are younger than eight years of age
- Evidence-Based Practices (EBP) requires prior approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State (Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services, Appendix D).
 - The institute of medicine (IOM) defines "evidence based practice" as a combination of the following three factors: (1) best research evidence, (2) best clinical experience, and (3) consistent with patient values (IOM, 2001). Implemented interventions using evidence-based techniques may ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation.

Family Peer Support Services (FPSS)

Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance abuse, and/or behavioral challenges in their home, school, placement, and/or community, FPSS provide a structured, strength based relationship between a Family Peer Advocate(FPA) and the parent/family member/caregiver for the benefit of the child/youth.

This service is needed to allow the child the best opportunity to remain in the community. Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth's treatment plan.

This service is needed to achieve specific outcome(s) such as: strengthening the family unit, building skills within the family for the benefit of the child, promoting empowerment within the family, and strengthening overall supports in the child's environment.

Admission Criteria

Any of the following criteria, (1 or 2,) and all criteria (3-5) must be met;

1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM OR

2. The child/youth displays demonstrated evidence of skill(s) lost or underdeveloped as a result of the impact of their physical health diagnosis, And;
3. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND
4. The child/youth's family is available, receptive to, and demonstrates needs for improvement in the following areas such as but not limited to:
 - a) Strengthening the family unit
 - b) Building skills within the family for the benefit of the child
 - c) Promoting empowerment within the family
 - d) Strengthening overall supports in the child's environment; AND
5. The services are recommended by the following Licensed Practitioners of the Health Arts operating within the scope of their practice under State License:
 - Licensed Master Social Worker
 - Licensed Clinical Social Worker
 - Licensed Mental Health Counselor
 - Licensed Creative Arts Therapist
 - Licensed Marriage and Family Therapist
 - Licensed Psychoanalyst
 - Licensed Psychologist
 - Physician's Assistant
 - Psychiatrist
 - Physician
 - Registered Professional Nurse or
 - Nurse Practitioner

Continued Stay Criteria

All of the following criteria, (1-7), must be met:

1. The child/youth continues to meet admission criteria. AND
2. The child/youth is making progress but has not fully reached established service goals and there is a reasonable expectation that continued service will increase the child/youth meeting service goals. AND
3. Family/caregiver(s) participation in treatment is adequate to meaningfully contribute to the child/youth's progress in achieving service goals, AND
4. Additional psychoeducation or training to assist the family caregiver understanding the child's progress and treatment or to care for the child would contribute to the child/youth's progress;; AND
5. The child/youth does not require an alternative and/or higher, more intensive level of care or treatment; AND
6. The child/youth is at risk of losing skills gained if the service is not continue; AND
7. Treatment planning includes family/caregiver(s) and/or other support systems, unless not clinically indicated or relevant

Discharge Criteria

Any one of the following criteria, (1 -6), must be met:

1. The child/youth and/or family no longer meets admission criteria OR

2. The child/youth has successfully met the specific goals outlined in the treatment plan for discharge; OR,
3. The family withdraws consent for services; OR
4. The child/youth and/or family is not making progress on an established service goals, nor is there expectation of any progress with continued provision of services; OR
5. The child/youth and/or family is no longer engaged in the services, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR
6. The family/caregiver(s) no longer needs this service as they are obtaining similar benefit through other services and resources

FPSS Limits/Exclusions

- The provider agency will assess the child prior to developing the treatment plan for the child.
- Treatment service must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visit
- A child with a development disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service
- A group cannot exceed more than 12 individuals in total
- The treatment plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The intervention plan must specify the amount, duration and scope of services. The intervention plan must be signed by the licensed mental health practitioner or physician responsible for developing the plan with the participant (or authorized representative) also signing a note occurrence with the treatment plan. The plan will specify a timeline for reevaluation of the plan that is at least a quarterly review. The reevaluation should involve the individual, family, and providers and include a reevaluation of plan to determine whether service have contributed to meeting the stated goals. A new intervention plan should be developed if there is no measurable reduction of disability or restoration of functional level. The new plan should identify different rehabilitation strategy with revised goals and services

Medicaid family support programs will not reimburse for the following:

- 12 -step groups run by peers
- General outreach and education including participation in health fairs and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services, community education service, such as health presentations to community groups, PTAs, etc.
- Contacts that are not medically necessary
- Time spent doing, attending, or participating in recreational activities
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, a teacher's aide, or an academic tutor
- Time spent attending school (e.g. during a day treatment program)
- Habilitative services for the beneficiary (child) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings
- Child care services or services provided as a substitute for the parent or other individual responsible for providing care and supervision
- Respite care
- Transportation for the beneficiary or family services provided in the car are considered transportation and time may not be billed under rehabilitation

- Services not identified on the beneficiary authorized treatment plan
- Service not in compliance with the service manual and not in compliance with State Medicaid standards
- Services provided to children, spouses, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's treatment plan
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed

Youth Peer Support and Training (YPST)

Youth peer support and training (YPST) services are formal and informal services and supports provided to youth, who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home, school placement and/or community centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills.

Youth Peer Support and Training activities must be intended to develop and achieve the identified goals and/or objectives as set forth in the youth's individualized treatment plan

The structured, scheduled activities provided by this service emphasize the opportunity for the youth to expand the skills and strategies necessary to move forward in meeting their personal, individualized life goals, develop self-advocacy skills, and to support their transition into adulthood.

Admission Criteria

One of the following criteria, (1 or 2), and all criteria (3-6) must be met:

1. The youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM;
OR
2. The youth displays demonstrated evidence of skill(s) lost or undeveloped as a result of the impact of their physical health diagnosis; AND
3. The youth requires involvement of a youth peer advocate to implement the intervention(s) outlines in the treatment plan, AND
4. The youth demonstrates a need for improvement in the following areas such as but not limited to a) Enhancing youth's abilities to effectively manage comprehensive health needs
 - b) Maintaining recovery
 - c) Strengthening resiliency, self-advocacy
 - d) Self-efficacy and empowerment
 - e) Developing competency to utilize resources and supports in the community.
 - f) Transition into adulthood or participates in treatment ; A ND
5. The youth is involved in the admission process and help determine service goals; AND
6. The youth is available and receptive to receiving this service, AND
7. The services are recommended by the following Licensed Practitioners of the Health Arts operating within the scope of their practice under State License:

- Licensed Master Social Worker
- Licensed Clinical Social Worker
- Licensed Mental Health Counselor
- Licensed Creative Arts Therapist
- Licensed Marriage and Family Therapist
- Licensed Psychoanalyst
- Licensed Psychologist
- Physician's Assistant
- Psychiatrist
- Physician
- Registered Professional Nurse or
- Nurse Practitioner

Continued Stay Criteria

All of the following criteria, (1-5), must be met:

1. The youth continues to meet admission criteria; AND
2. The youth shows evidence of engagement toward resolution of symptoms but has not fully reached established service goals and there is expectation that if the service continues, the youth will continue to improve; AND
3. The youth does not require an alternative and/or higher, more intensive level of care or treatment; A ND
4. The youth is at risk for losing skills gained if the service is not continued; AND
5. Treatment planning includes family/caregiver(s) and/or other support systems, unless not clinically indicated

Discharge Criteria

Any one of the following criteria, (1 -6), must be met:

- 1) The youth no longer meets admission criteria OR
- 2) The youth has successfully met the specific goals outlined in the treatment plan for discharge; OR
- 3) The youth or parent/caregiver withdraws consent for services; OR
- 4) The youth is not making progress on an established service goal, nor is there expectation of any progress with continued provision of services; OR
- 5) The youth is no longer engaged in the services, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR
- 6) The youth no longer needs this service as they are obtaining similar benefit through other services and resources

YPST Limits/Exclusions

- The provider agency will assess the child prior to developing the treatment plan for the child.
- Treatment service must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visit

- A youth with a development disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service
- A group is composed of 2 or more youths and cannot exceed more than 12 individuals in total
- The intervention plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The intervention plan must specify the amount, duration and scope of services. The intervention plan must be signed by the licensed mental health practitioner or physician responsible for developing the plan with the participant (or authorized representative) also signing a note occurrence with the treatment plan. The plan will specify a timeline for reevaluation of the plan that is at least a quarterly review. The reevaluation should involve the individual, family, and providers and include a reevaluation of plan to determine whether service have contributed to meeting the stated goals. A new treatment plan should be developed if there is no measurable reduction of disability or restoration of functional level. The new plan should identify different rehabilitation strategy with revised goals and services

Medicaid family support programs will not reimburse for the following

- 12 -step groups run by peers
- General outreach and education including participation in health fairs and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services, community education service, such as health presentations to community groups, PTAs, etc.
- Contacts that are not medically necessary
- Time spent doing, attending, or participating in recreational activities
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, a teacher's aide, or an academic tutor
- Time spent attending school (e.g. during a day treatment program)
- Habilitative services for the beneficiary (child) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings
- Child care services or services provided as a substitute for the parent or other individual responsible for providing care and supervision
- Respite care
- Transportation for the beneficiary or family services provided in the car are considered transportation and time may not be billed under rehabilitation

- Services not identified on the beneficiary authorized treatment plan
- Service not in compliance with the service manual and not in compliance with State Medicaid standards
- Services provided to children, spouses, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's treatment plan
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed

Crisis Intervention (CI)

Crisis Intervention (CI) services are provided to children/youth who are identified as experiencing an acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g. collateral, provider, community member) to effectively resolve it. A child/youth in crisis may be referred by a family member or other collateral contact who has knowledge of the child/youth's capabilities and functioning. The goals of CI are engagement, symptom reduction, stabilization, and restoring individuals to a previous level of functioning or developing the coping mechanisms to minimize or prevent the crisis in the future.

Admission Criteria

All of the following criteria, (1-4), must be met:

1. The child/youth experiencing acute psychological/emotional changes which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g. collateral, provider, community member) to effectively resolve it; AND
2. The child/youth demonstrates at least one of the following:
 - a) Suicidal/assaultive/destructive ideas, threats, plans or actions that represent a risk to self or others; or
 - b) Impairment in mood/thought/behavior disruptive to home, school, or the community, or
 - c) Behavior escalating to the extent that a higher intensity or service will likely be required; AND
3. The intervention is necessary to further evaluate, resolve, and/or stabilize the youth; AND
4. The services are recommended by the following Licensed Practitioners of the Healing Arts operating within the scope of their practice under State License:
 - a) Psychiatrist
 - b) Physician
 - c) Licensed Psychoanalyst
 - d) Registered Professional Nurse
 - e) Nurse Practitioner
 - f) Clinical Nurse Specialist
 - g) Licensed Clinical Social worker
 - h) Licensed Marriage and Family Therapist
 - i) Licensed Mental Health Counselor or
 - j) Licensed Psychologist

Continued Stay Criteria

N/A

Discharge Criteria

Any one of the following criteria, (1 or 2), must be met:

1. The child/youth no longer meets admission criteria (demonstrates symptom reduction, stabilization, and restoration, or developing the coping mechanisms to pre-crisis levels of functioning) and/or meets criteria for another level of care. Either more or less intensive; OR
2. The child/youth or parent/caregiver(s) withdraws consent for services

Crisis Intervention Limits/Exclusions

- Within the 72-hour timeframe of a crisis, de-escalation techniques are utilized in an attempt to calm the child, information is gathered from the child, family, and/or other collateral supports on what may have triggered the crisis; information is gathered on the child's history; review of medication occurs, as appropriate, and a crisis plan is developed with the child/family. Warm handoff to providers of needed services should be occurring following these expectations.
- The following activities are excluded: financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature
- Services may not be primarily educational, vocational, recreational, and or custodial (i.e. for the purpose of assisting in the activities of daily living such as bathing, dressing, eating, and maintaining personal hygiene and safety; for maintaining the recipients or anyone else's safety, and could be provided by persons without professional skills or training).Services also do not include services, supplies or procedures performed in a nonconventional setting including, resorts, spas, therapeutic programs, and camps. Once the current crisis episode and follow up exceeds 72 hours, then it shall be considered a new crisis intervention episode or will be transferred to a longer-term service for rehabilitation skill-building such as CPST. An episode is defined as starting with the initial face-to-face contact with the child.
- The child/youth's chart must reflect resolution of the crisis, which marks the end of the episode. Warm hand off to follow up service with a developed plan should follow.

Adult's Home and Community Based Services (HCBS)

Home and Community Based Services (HCBS) provide opportunities for Medicaid beneficiaries with mental illness and/or substance use disorders who are enrolled in a Health and Recovery Plan (HARP) to receive services in their own home or community. Implementation of HCBS will help to create an environment where managed care plans (Plans), Health Home care managers, service providers, plan members and their chosen supporters/caregivers, and government partners help members prevent, manage, and ameliorate chronic health conditions and recover from serious mental illness and substance use disorders. These review guidelines provide a framework for discussion between HCBS providers and Plans. The review process is collaboration between all pertinent participants including but not limited to the Health Home care manager, HCBS provider, Plan and member to review progress and identify barriers or challenges that may be interfering with a reasonable expectation of progress towards the member's chosen goals. These conversations will focus on the member's needs, strengths, and history in determining the best and most appropriate fit of the services. These review guidelines are applied to determine appropriate care for all members. In general, services will be authorized if they meet the specific criteria for a particular service. The individual's needs, choice, and individual's Health Home(HH) care manager. Provision of Home and Community Based Services requires a person-centered approach to care planning, service authorizations, and service delivery. MCO utilization management for HCBS must conform to guidelines listed in the NYS HCBS Provider Manual (latest version available at: <https://www.omh.ny.gov/omhweb/guidance/hcbs/html/services -application/>). This manual outlines how HCBS care planning and utilization management emphasizes attention to member strengths, goals and preferences, and ensures member choice of service options and providers.

The following is a description of the various HCBS services:

Community Rehabilitation Services

Many of the HCBS services are designed to be provided in clusters that promote recovery along a spectrum, and as such, Psychosocial Rehabilitation (PSR) and Community Psychiatric Support and Treatment (CPST) are designated as a cluster.

Psychosocial Rehabilitation (PSR)

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

Community Psychiatric Support and Treatment (CPST)

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

Vocational Services

Many of the HCBS services are designed to be provided in clusters that promote recovery along a spectrum and as such, Employment Support Services are grouped as a cluster and include Pre-Vocational Services, Transitional Employment, Intensive Supported Employment, and Ongoing Supported Employment.

Pre-vocational Services

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

The outcome of this pre-vocational activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

Transitional Employment (TE)

This service is designed to strengthen the participant's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, psychosocial club

program certified provider or recovery center. This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non -job- task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

Intensive Supported Employment (ISE)

ISE services that assist individuals with MH/SUD to obtain and keep competitive employment. These services consist of intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service will follow the evidence based principles of the Individual Placement and Support (IPS) model. This service is based on Individual Placement Support (IPS) model which is an evidence based practice of supported employment. It consists of intensive supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting.

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

Ongoing Supported Employment

This service is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position. Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement.

Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

Short-Term Crisis Respite Services

Short-term Crisis Respite

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

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

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

Intensive Crisis Respite

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

Education Support Services

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

Education Support Services must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. Examples of these goals would include, but not be limited to: tutoring or formal classes to obtain a Test Assessing Secondary Completion (TASC) diploma, vocational training, apprenticeship program or formal classes to improve skills or knowledge in a chosen career, community college, university or any college-level courses or classes.

Empowerment/Peer Support Services

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

Habilitation/Residential Support Services

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

Family Support and Training

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

Admission Criteria

All of the following criteria, (1-7), must be met:

1. The member must be deemed eligible to receive HCBS using the HCBS Eligibility Assessment tool.
2. Where the member has been deemed eligible to receive services, a Level of Service Determination is made to ensure recommended HCBS are appropriate for meeting the member's identified goals, and appropriate HCBS provider(s)are identified in a conflict-free manner.
3. Upon receipt of notification from the HCBS provider(s), up to 3 visits over 14days is authorized for intake and evaluation.
4. The BH Prior and/or Continuing Authorization Request Form is submitted by the HCBS provider(s) for Prior Authorization and includes service scope, duration and frequency.
5. The service request must support the member's efforts to manage their condition(s) while establishing a purposeful life and sense of membership in a broader community.
6. The member must be willing to receive home and community based services.
7. There is no alternative level of care or co-occurring service that would better address the member's clinical needs.

Continued Stay Criteria

All of the following criteria, (1-5), must be met:

1. Member continues to meet admission criteria and an alternative service would not better serve the member.
2. Interventions are timely, need based as per the CMHA (Full Assessment) consistent with evidence based/best practice, and provided by a designated HCBS provider.
3. One of the following is present:
 - a) Member is making measureable progress towards a set of clearly defined goals; Or
 - b) There is evidence that the service plan is modified to address the barriers in treatment progression, or,
 - c) Continuation of services is necessary to maintain progress already achieved and/or prevent deterioration.
4. There is care coordination with physical and behavioral health providers State, and other community agencies.
5. Family/guardian/caregiver is participating in treatment where appropriate.

In addition, determination of progress and modifications to goals/objectives are made by reviewing the BH HCBS Prior and/or Continuing Authorization Request Form and/or with a telephonic review with the provider.

Discharge Criteria

Any one of the following criteria, (1 -5),must be met; criteria 6 is recommended, but optional:

1. Member no longer meets admission criteria and/or meets criteria for another, more appropriate service, either more or less intensive.
2. Member or parent/guardian withdraws consent for treatment.
3. Member does not appear to be participating.
4. Member's needs have changed and current services are not meeting these needs. Member's self- identified recovery goals would be better served with an alternate service and/or service level. As a component of the expected discharge, alternative services are being explored in collaboration with the member, the member's family members (if applicable), Health Home, HCBS provider, and MCO.
5. Member's goals have been met.
6. Member's support system is in agreement with the aftercare service plan.

Children's Home and Community Based Services (HCBS)

Home and Community Based Services (HCBS) are designed to allow children/youth to participate in a vast array of rehabilitative service, by granting access to a series of Medicaid funded services. New York (NY) has affirmed its commitment to serving individuals in the least restrictive environment by providing services and supports to children and their families to enable them to remain at home and in the community. HCBS are designed for people who, but for these services, require the level of care provider in a more restrictive environment such as in a long-term care facility or psychiatric inpatient care and for those at risk of elevating to that level of care.

The Medicaid Managed Care transition for individual under the age of 21 includes the alignment of the following NY children's' waivers currently accessible under the authority of the 1915 (c) amendment of the Federal Social Security Act: Office of Children and Family Services (OCFS) Bridges to Health [B2H Serious Emotional Disturbance (SED), B2H Development Disabilities (DD), B2H medically fragile (MedF), the Office of Mental Health (OMH) SEDWaiver, Office for People with Developmental Disabilities (OPWDD) Care at Home (CAH) waiver and the Department of Health (DOH)-operated Care at Home (CAH) I/II Waiver

The Office of Addiction Services and Supports (OASAS), OCFS, OMH, and DOH have worked in collaboration to create a newly aligned service array of HCBS benefits for children meeting specific criteria. The 1115 Medicaid Redesign Team (MRT) Waiver, with approval from the Centers for Medicare and Medicaid Services (CMS), provides NYS the authority for these HCBS benefits. Included in the 1115 are person-centered planning requirements as well as specifics on the transitional coverage requirement for children currently enrolled in 1915(c) waivers at the time of transition.

HCBS eligibility includes: 1) target criteria; 2) risk factors and 3) functional criteria as well as Medicaid eligibility. These criteria are currently limited to children that would otherwise qualify for institutional placement Level of Care (LOC) criteria. The 1115 federal authority seeks to expand LOC to include a new needs-based criteria category referred to as Level of Need, allowing more children to access HCBS benefits. This expansion group addresses gaps in service where a child who may benefit from HCBS was not eligible based on higher functioning.

New York State will continue to use the comprehensive Child and Adolescent Needs and Strengths (CANS) assessment tool to assure person-centered services planning for HCBS-eligible children/youth.

MCO utilization management for HCBS must conform to guidelines listed in the NYS HCBS Provider Manual, Latest version available at: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/hcbs_manual.pdf

The following is a description of the various HCBS services:

Habilitation

Habilitation services assists children/youth with developmental, medical or behavioral disabilities with the self- help, socialization, and adaptive skills necessary for successful functioning in the home and community.

Caregiver/Family Supports and Services

Caregiver/Family Supports and Services enhance the child/youth's ability regardless of disability (developmental, physical and/or behavioral), to function as part of a caregiver/family unit and enhance the caregiver/family's ability to care for the child/youth in the home and/or community. Family is broadly defined, and can include families created through: birth, foster care, adoption, or a self-created unit.

Note: this service is not the State Plan service of Family Peer Support Services, which is delivered by a certified Family Peer with lived experience.

Respite

This service focuses on short-term assistance and/or relief for children/youth with disabilities (developmental, physical and/or behavioral), and family/caregivers which can be provided in a planned mode or delivered in a crisis environment. Respite workers supervise the child/youth and engage the child in activities that support his/her and or caregiver/family's constructive interests and abilities.

Respite providers will offer services with a level of expertise in understanding and implementing behavioral/ developmental interventions required to support optimal functioning for children/youth. Respite providers will regularly communicate the details of the child/youth's intervention plan so that there is a carry-over of skill from the respite source to the caregivers and treatment providers.

To the extent that skilled nursing is provided as a form of respite, this service has to be ordered by a physician.

Prevocational Services

Prevocational Services are individually designed to prepare a youth (age 14 or older) to engage in paid work, volunteer work or career exploration. Prevocational Services are not job-specific, but rather are geared toward facilitating success in any work environment for youth whose disabilities do not permit them access to other prevocational services. The service will be reflected in youth's plan of care and must be directed to teaching skills rather than explicit employment objectives. In addition, Prevocational Services assist with facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements.

Prevocational Services may include volunteer work, such as learning and training activities that prepare a person for entry into the paid workforce. Prevocational Services should enable each participant to attain the highest level of work in the most integrated setting and with the job matched to the participant's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines from the U.S. Department of Labor. Services are intended to develop and teach general skills. Examples include, but are not limited to:

- ability to communicate effectively with supervisors,
- co-workers and customers;
- generally accepted community workplace conduct and dress;
- ability to follow directions;
- ability to attend to and complete tasks;
- punctuality and attendance;
- appropriate behaviors in and outside the workplace;
- workplace problem solving skills and strategies;
- mobility training; career planning;
- proper use of job-related equipment and general workplace safety

Prevocational Services include activities that are not primarily directed at teaching skills to perform a particular job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform work and optimally to perform competitive, integrated employment.

Prevocational services will not be provided to an HCBS participant if:

1. Special education and related services that are otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA).
2. Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (Access VR).
3. Vocational services that are provided in facility based work settings that are not integrated settings in the general community workforce.

Supported Employment

Supported Employment services are individually designed to prepare youth with disabilities (age 14 or older) to engage in paid work. Supported Employment services provide assistance to participants with disabilities as they perform in a work setting. Supported Employment provides ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work-setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employers, job analysis, job carving, training and systematic instruction, job coaching, benefit support, training and planning, transportation, career advancement services, and other workplace support services including services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting.

Supported employment services may also include services and supports that assist the participant in achieving self-employment through the operation of a business including home-based self-employment. However, Medicaid funds are not used to defray the expenses associated with starting up or operating a business.

In addition to the need for an appropriate job match that meets the individual's skills and interests, individuals may also need long term employment support to successfully maintain a job due to the ongoing nature of the HCBS participant's support needs, changes in life situations, or evolving and changing job responsibilities.

Supported Employment service will not be provided to an HCBS participant if:

- 1) Special education and related services that is otherwise available to the individual through a local educational agency, under the provisions of the Individuals with Disabilities Education Act (IDEA).
- 2) Vocational rehabilitation services that are otherwise available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973.
- 3) Supported employment does not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.
- 4) Supported employment does not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.
- 5) Supported employment does not include volunteer work. Such volunteer learning and un-paid training activities that prepare a person for entry into the paid workforce are addressed through pre-vocational services.

Medicaid funding cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
- Payments that are passed through to users of supported employment services.

Community Self-Advocacy Training and Supports

Participating in community events and integrated interests/occupations are important activities for all children/youth, including those with disabilities (developmental, physical and/or behavioral health in origin). Success in these activities is dependent not only on the child/youth, but on the people who interact with and support the child/youth in these endeavors. Community Self-Advocacy Training and Support improves the child/youth's ability to gain from the community experience, and enables the child/youth's environment to respond appropriately to the child/youth's disability and/or health care issues.

Community Self-Advocacy Training and Support is intended to assist the child/youth, family/caregiver, and collateral contacts in understanding and addressing the participant's needs related to their disability(ies).

Community Self-Advocacy Training and Support provides family, caregivers, and collateral contacts with techniques and information not generally available so that they can better respond to the needs of the participant. The use of this service may appropriately be provided to prevent problems in community settings as well as when the child/youth is experiencing difficulty. The Plan of Care objectives must clearly state how the service can prevent as well as ameliorate existing problems and to what degree. This service cannot be used to develop an Individualized Education Program (IEP), the plan for students with disabilities who meet the federal and state requirements for special education, or to provide special education services to the child/youth.

Non-Medical Transportation

Non-Medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical Transportation services are available for individuals to access authorized HCBS and destinations that are related to a goal included on the child/youth's Plan of Care.

Examples where this service may be requested include transportation to: HCBS that a child/youth was determined eligible to receive; a job interview, college fair, wellness seminar, a GED preparatory class, etc. This service will be provided to meet the child/youth's needs as determined by an assessment performed in accordance with the state's requirements and as outlined in the child/youth's Plan of Care.

Section 3: OASAS LOCADTR 3.0 Criteria

Overview

Beacon Health Options adopts the Office of Addiction Support and Services (OASAS) Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) 3 .0 for use in rendering medical necessity determinations for all substance use services for all lines of business (excluding Medicare) for providers located in New York State.

NYS OASAS, in partnership with National Center on Addiction and Substance Abuse at Columbia University (CASA Columbia), developed the LOCADTR 3 .0, a web-based tool, to assist substance abuse treatment providers, Medicaid Managed Care plans, and other referral sources in determining the most appropriate level of care (LOC) for a client with a substance use disorder. This tool enables the referral source to identify the most appropriate treatment setting closest to the client's community.

The LOCA DTR 3.0 Manual can be found here:

<https://oasas.ny.gov/system/files/documents/2019/10/LOCADTRManual3.0.pdf>

The LOCA DTR 3.0 Concurrent Review Manual can be found here:

https://oasas.ny.gov/system/files/documents/2019/10/CRMANUAL19June2019_Final%20%281%29.pdf

The following is a list of services for which LOCADTR Criteria is used:

- A. Inpatient Detoxification (Medically Managed and Medically Supervised)**
 - B. Inpatient Rehabilitation/ Residential Rehabilitation for Youth**
 - C. Residential (Stabilization and Rehabilitation)**
 - D. Outpatient Detoxification/ Withdrawal**
 - E. Outpatient Day Rehabilitation / Partial Hospital**
 - F. Intensive Outpatient**
 - G. Opioid Treatment Programs**
 - H. Outpatient Clinic Services**
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Section 4: InterQual Criteria Overview

Beacon Health Options adopts Change Healthcare's InterQual Behavioral Health Criteria for use in rendering medical necessity determinations for all mental health services in which CMS and OMH criteria is not applicable or available.

The Beacon book view can be found by registering and logging into the InterQual portal here:

<https://mncex.beaconhealthoptions.com/mncportal/criteria/>

The following is a list of services for which InterQual Criteria is used:

Adults	Child and Adolescent	BH: Procedures Q&A
<ul style="list-style-type: none">• Inpatient• Observation• Residential Crisis Program• Residential Treatment Center• Supervised Living• Partial Hospital Program• Day Treatment Program• Home Care• Intensive Community Based Treatment• Intensive Outpatient Program• Outpatient	<ul style="list-style-type: none">• Inpatient• Observation• Residential Crisis Program• Subacute Care• Residential Treatment Center• Supervised Living• Partial Hospital Program• Day Treatment Program• Intensive Community Based Treatment• Intensive Outpatient Program• Outpatient	<ul style="list-style-type: none">• Applied Behavior Analysis (ABA)• Biofeedback• Electroconvulsive Therapy (ECT)• Multi-Gene Panels for Autism (ASD)• Neuropsychological and Developmental Testing• Pharmacogenomics Testing for Psychotropic Medication Drug Response• Psychological testing• Stereotactic Introduction, Subcortical Electrodes• Transcranial Magnetic Stimulation (TMS)• Urine Drug Testing• Vagus Nerve Stimulation

Section 5: ASAM Criteria

Overview

Beacon Health Options adopts the American Society for Addiction Medicine (ASAM) Criteria for use in medical necessity determinations for all substance use services for all Medicare members (for which CMS Criteria is not available) and for all other lines of business when the provider is located outside of New York State.

An introduction to A SAM can be found here: <https://www.beaconhealthoptions.com/pdf/members/Introduction-to-The-ASAM-Criteria-for-Patients-and-Families.pdf>

The following is a list of services in which A SAM Criteria is used:

- A. Early Intervention**
- B. Opioid Treatment Program**
- C. Outpatient Services**
- D. Intensive Outpatient Services**
- E. Partial Hospitalization Services**
- F. Residential Services**
- G. Inpatient Services**
- H. Withdrawal Management (Ambulatory, Residential, Inpatient)**