carelon

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

Behavioral Health Policy and Procedure Manual for Providers / Independent Health®

Independent Health

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

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The following information is available via the health plan-specific Contact information sheet available on Beacon's website at www.beaconhealthoptions.com

- Health plan name
- Health plan EDI code
- Beacon hours of operation
- Beacon Ombudsperson phone number
- Beacon TTY
- Beacon's Member Services phone number
- Beacon Provider Relations phone number
- Interactive Voice Recognition (IVR)
- Beacon Clinical Appeals Coordinator phone number
- Beacon Claims Department address and phone number
- Plan/state required filing notice filing limit
- Time limits for filing inpatient claims
- Time limits for filing outpatient claims
- Number of days from determination to request a fair hearing
- State Fair Hearing Office address and phone number
- State External Appeals Office address and phone number

Chapter 1

Introduction

1.1. Introduction to Beacon

Beacon Health Options (Beacon) is a family of companies that provides best-in-class behavioral health solutions for regional and specialty health plans; employers and labor organizations; and federal, state and local governments. Beacon's mission is to partner with our health plan customers and contracted providers to improve the delivery of behavioral healthcare for the members we serve.

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

1.2. About this Provider Manual

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

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

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

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

1.3. Quality Improvement Efforts Focus on Integrated Care

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

1.4. Behavioral Health Services

DEFINITION OF BEHAVIORAL HEALTH

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

ACCESSIBLE INTERVENTION AND TREATMENT

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

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

OUTPATIENT BENEFITS

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

INPATIENT BENEFITS

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

1.5. Primary Care Provider Requirements for Behavioral Health

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.

Chapter 2

Network Operations

2.1. Network Operations and Network Development

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

2.2. Contracting and Maintaining Network Participation

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

2.3. Provider Credentialing and Recredentialing

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

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

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

- If a clinician is not board-certified, his/her education and training, including evidence of graduation from the appropriate professional school and completion of a residency or specialty training, are verified. Primary source verification shall be sought from the appropriate schools and training facilities. If the state licensing board or agency verifies education and training with the physician or provider schools and facilities, evidence of current state licensure shall also serve as primary source verification of education and training.
- If the physician states that he/she is board-certified on the application, primary source verification may be obtained from the American Board of Medical Specialties, the American Osteopathic Association, the American Medical Association Master File, or from the specialty boards.

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

- Malpractice history from the National Practitioner Data Bank
- Information on previous sanction activity by Medicare and Medicaid
- Copy of a valid Drug Enforcement Agency (DEA) and Department of Public Safety Controlled Substance permit, if applicable

- Evidence of current, adequate malpractice insurance meeting the HMO's requirements
- Information about sanctions or limitations on licensure from the applicable state licensing agency or board
- Federal Disclosure of Ownership Form
    - The Federal Ownership of Disclosure Form is required by Beacon to ensure that Beacon is not contracting with any providers/groups excluded from Federal and State programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, or has civil monetary penalties imposed against them.

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, 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 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 30 days to respond to initial notice. Specific time frame to respond will be indicated in the notice.

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

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

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.

RECREDENTIALING

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

- Licensure
- Clinical privileges
- Board certification

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

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

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

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

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

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

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

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

2.5. Credentialing Process Overview

INDIVIDUAL PRACTITIONER CREDENTIALING	ORGANIZATIONAL CREDENTIALING
Beacon individually credentials the following categories of clinicians in private or solo or practice settings: ▪ Licensed Psychiatrist ▪ Physician certified in addiction medicine ▪ Licensed Psychologist ▪ Licensed Independent Clinical Social Worker ▪ Licensed Independent Counselor ▪ Master's-Level Clinical Nurse Specialists/Psychiatric Nurses ▪ Licensed Mental Health Counselors ▪ Licensed Marriage and Family Therapists ▪ Other behavioral healthcare specialists who are master's level or above and who are independently licensed, certified, or registered by the state in which they practice	Beacon credentials and recredentials facilities and licensed outpatient agencies as organizations. Facilities that must be credentialed by Beacon as organizations include: ▪ Licensed outpatient clinics and agencies, including hospital-based clinics ▪ Freestanding inpatient mental health facilities – freestanding and within general hospital ▪ Inpatient mental health units at general hospitals ▪ Inpatient detoxification facilities ▪ Other diversionary mental health and substance use disorder services including: 1. Partial hospitalization 2. Day treatment 3. Intensive outpatient 4. Residential 5. Substance use rehabilitation

2.6. 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.

Chapter 3

Quality Management and Improvement Program

3.1. 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

3.2. Provider Role

Beacon employs a collaborative model of continuous Quality Management and Improvement QM & I), 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 QM & I Program to continually assess quality of care, access to care and compliance with medical necessity criteria.

To participate in Beacon's Provider Stakeholders committee, email provider.relations@beaconhealthoptions.com. Members who wish to participate in the Member Advisory Council should contact the Member Services Department.

3.3. 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 potential quality of care concerns, 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 potential quality of care concerns 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.

3.4. 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 assessment suicide risk, substance use, 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 Compliance & Privacy Office at compliance@beaconhealthoptions.com.

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

TREATMENT RECORD STANDARDS

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

Member Identification Information

The treatment record contains the following member information:

- Member name and health plan identification # on every page
- Member's address
- Employer or school
- Home and work telephone number
- Marital/legal status
- Appropriate consent forms
- Guardianship information, if applicable

Informed Member Consent for Treatment

The treatment record contains signed consents for the following:

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

Medication Information

The treatment records contain medication logs clearly documenting the following:

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

Medical and Psychiatric History

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

- Previous dates of treatment
- Names of providers
- Therapeutic interventions
- Effectiveness of previous interventions
- Sources of clinical information
- Relevant family information
- Results of relevant laboratory tests
- Previous consultation and evaluation reports

Substance Abuse Information

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

- Cigarettes
- Alcohol
- 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.

3.5. 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

3.6. Practice Guidelines and Evidence-Based Practices

Beacon and the health plan promote delivery of behavioral health treatment based on scientifically proven methods. We have researched and adopted evidenced-based guidelines for treating the most prevalent behavioral health diagnoses, including guidelines for ADHD, Schizophrenia, Substance Use Disorders, and posted links to these on our website. We strongly encourage providers to use these guidelines and to consider these guidelines wherever they may promote positive outcomes for clients. Beacon monitors provider utilization of guidelines through the use of claim, pharmacy and utilization data.

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.

3.7. 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.

3.8. 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.

3.9. 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 as specified above to the receiving provider.

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

3.10. Member Safety Program

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

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

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

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

1. Surgical or Invasive Procedures (i.e., wrong site, wrong patient, wrong procedure, foreign object, and death of ASA class 1 patient)

2. Product or Device Events (i.e., contamination, device malfunction, and embolism)

3. Patient Protection Events (i.e. discharge of someone unable to make decisions, elopement, completed suicide, attempted suicide, and self-injurious behaviors)

4. Care Management Events (i.e., medication error, fall)

5. Environmental Events (i.e., electric shock, gas, burn, restraint, seclusion, restrictive interventions)

6. Potential Criminal Events (i.e., impersonation, abduction, physical assault, and sexual behavior)

7. Beacon Specific (such as disaster management, accidents, staff misconduct, standards of care, and natural death)

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

 Provider inappropriate/unprofessional behavior

- Inappropriate boundaries/relationship with member
- Practitioner not qualified to perform services
- Aggressive behavior
- Displays signs of cognitive, mental health, or substance use concerns impacting the care being provided

 Clinical practice-related issues

- Abandoned member or inadequate discharge planning
- Timeliness, accuracy, or adequacy of diagnosis, assessment, or referral
- Delay in treatment
- Effectiveness of treatment
- Failure to coordinate care or follow clinical practice guidelines
- Failure to involve family in treatment when appropriate
- Medication error or reaction
- Treatment setting not safe

 Access to care-related issues

- Failure to provide appropriate appointment access
- Lack of timely response to telephone calls
- Prolonged in-office wait time or failure to keep appointment
- Provider non-compliant with American Disabilities Act (ADA) requirements
- Services not available or session too short

 Attitude and service-related issues

- Failure to allow site visit
- Failure to maintain confidentiality
- Failure to release medical records
- Fraud and abuse
- Lack of caring/concern or poor communication skills
- Poor or lack of documentation
- Provider/staff rude or inappropriate attitude

 Other monitored events

- Adverse reaction to treatment
- Failure to have or follow communicable disease protocols
- Human rights violations
- Ingestion of an unauthorized substance in a treatment setting
- Non-serious injuries (including falls)
- Property damage and/or fire setting
- Sexual behavior

Participating providers are required to report to Beacon within 24 hours all Potential Quality of Care (PQOC) concerns involving members. A copy of the "Reporting a Potential Quality of Care Concern: Provider Form," which includes instructions to submit, can be found on Beacon's Provider Website in the Clinical Forms section.

Beacon investigates Potential Quality of Care Concerns (PQOC) and uses the data generated to identify opportunities for improvement in the clinical care and service members receive. Beacon tracks and trends PQOC concerns and when necessary, investigates patterns or prevalence of incidents and uses the data generated to identify opportunities for quality improvement.

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

3.11. Provider Responsibilities

MEMBERS DISCHARGED FROM INPATIENT PSYCHIATRIC FACILITIES

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

Providers should be prepared to present:

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

PRIMARY CARE PROVIDERS

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

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

UPDATES TO CONTACT INFORMATION

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

Chapter 4

Providerand Member Complaint and Appeals Process

4.1. Complaints and Grievances

Providers with complaints/grievances or concerns should contact their Beacon-contracted office and ask to speak with the clinical manager for the plan. All provider complaints are thoroughly researched by Beacon and resolutions proposed within 30 business days.

If a plan member complains or expresses concerns regarding Beacon's procedures or services, health plan procedures, covered benefits or services, or any aspect of the member's care received from providers, he or she should be directed to call Beacon's Ombudsperson who is associated with that particular health plan. Please refer to the health plan-specific contact information at the end of this manual.

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

Beacon reviews and provides a timely response and resolution of all complaint/grievances that are submitted by members, authorized member representative (AMR), and/or providers. Every complaint/ grievance is thoroughly investigated, and receives fair consideration and timely determination.

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

If the complaint/grievance is determined to be urgent, the resolution is communicated to the member and/or provider verbally within 24 hours, and then in writing within 30 calendar days of receipt of the complaint/grievance. If the complaint/grievance is determined to be non-urgent, Beacon's ombudsperson will notify the person who filed the complaint/grievance of the disposition of his/her complaint/grievance in writing, within 30 calendar days of receipt.

For both urgent and non-urgent complaints/grievances, the resolution letter informs the member or member's representative to contact Beacon's ombudsperson in the event that he/she is dissatisfied with Beacon's resolution.

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

APPEALS OF COMPLAINT/GRIEVANCE RESOLUTIONS

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

The member or member representative has 30-60 calendar days [depending on state regulation] after receipt of notice of the resolution to file a written or verbal appeal.

Appeals of complaint/grievance resolutions are reviewed by Beacon's Peer Review Committee and assigned to an account manager from another health plan to review and make a determination. This determination will be made in a time frame that accommodates the urgency of the situation but no more than 10 business days. Notification of the appeal resolution will be telephonic on the same day of the

resolution for urgent complaints/grievances. Written notification will be made within 1-2 business days of the appeal decision (time frames according to state regulation).

4.2. 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 at 855.371.9228.

When a reconsideration is requested, a physician advisor, 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.

4.3. 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.

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.

Punitive action is never taken against a provider who requests an appeal or who supports a member's request for an appeal.

Overview of Clinical Appeals

For Medicaid, FHP, CHP and Medicare members, the appeal request must be filed within 60 days after notification of the adverse determination. For members with commercial coverage, the appeal request must be filed within 180 days after the notification.

Members are offered the right of representation throughout the appeals process. If the member designates an AMR to act on their behalf, Beacon will attempt to obtain a signed and dated Authorization of Representative form. Beacon may communicate verbally and in writing with a provider who initiated an appeal on the member's behalf, or with an individual whom the member verbally designated as their representative.

Members, AMRs and providers have the opportunity to submit written comments, documents and other information concerning the appeal.

All medical necessity appeals are conducted by a Physician or Psychologist Advisor (PA) who was not the physician/psychologist that made the original adverse determination, nor is the subordinate of that physician/psychologist. The PA conducting the appeal must hold an active, unrestricted license to practice medicine/psychology, (and have the same license status as the ordering practitioner) in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. The PA reviews all available information and, in the case of expedited appeals, attempts to speak with the member's

attending physician.

Appeals are processed as standard (non-expedited) appeals unless they meet the definition of urgent care, in which case expedited review timeframes apply. Urgent Care is any request for medical care or treatment with respect to which the applications of the standard time-periods for making non-urgent care decisions:

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

For expedited appeals, a decision is made within 24 to 72 hours, depending on line of business and state regulations. For standard appeals, a decision is made within 30 calendar days of the request, depending on line of business and state regulations. Written notification of the decision is sent to the provider and the member within one to two business days after the appeal decision, subject to plan-, program- and state-specific requirements.

If an appeal requires review of medical records, an Authorization to Release Medical Information form signed by the member or AMR. The provider must submit the medical chart for review. If the medical record with Authorization to Release Medical Information Form is not received prior to the deadline for resolving the appeal, a resolution will be rendered based on the information available.

The outcome of a level 1 appeal, if upheld, is considered a Final Adverse Determination (FAD).

Peer Review

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

Extension of Benefits (Aid in Continuing)

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:

- 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 did not expire before the appeal
- The member requested an extension of the benefits

4.4. Administrative Appeal Processes

An administrative denial is an adverse determination issued on a basis other than medical necessity or experimental/investigational services. Appeals of administrative denials are reviewed according to the same process as clinical appeals, except that non-clinical staff may make administrative appeal determinations; a physician/psychologist advisor is not required.

Expedited administrative appeals are decided as expeditiously as the member's condition requires and, subject to plan- and state-specific requirements, within 2 business days of receipt of all necessary

information and within 72 hours after receipt of the appeal request. Standard administrative appeals are decided within 30 calendar days after receipt, subject to plan-, program- and state-specific requirements.

4.5. State Fair Hearing for Medicaid Members

In accordance with SSL 22, 364-j (9), 18 NYCRR 358, all Medicaid recipients shall be afforded the right to a fair hearing under appropriate circumstances. The federal government and the New York State Department of Health require the Fair Hearing provisions. Medicaid recipients are informed of their right to apply to the New York State Department of Health Office of Administrative Hearings when they feel a managed care plan, local Department of Social Services, or provider has wrongly limited their Medicaid benefits.

Beacon, and the health plans with which it holds contracts, are required to provide information to Medicaid members about their right to a fair hearing whenever the following occurs:

- Requested services are denied because they are not medically necessary or are not part of the covered benefit package
- Requested continued services are denied, reduced, suspended or terminated

Members or their representatives may request an expedited State Fair Hearing with the state.

Participating providers should be aware of Beacon policies, regarding fair hearings, which comply with applicable regulations. A Medicaid member may be entitled to appeal a Beacon decision sequentially or concurrently through the Beacon appeal process, the New York State external review process and the New York State Office of Administrative Hearings process. For Medicaid Members, the fair hearing decision is ultimately binding. Inquiries regarding this fair hearing procedure should be directed to the Beacon Clinical Program Manager for the member's plan.

A Medicaid member or their representative may request a New York State Fair Hearing by contacting:

NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023

www.otda.state.ny.us/oah

For assistance in filing a request for a State Fair Hearing, you may contact Beacon's Member Services Department 855.371.9228. You may also request assistance by sending a written request to Beacon's Appeals Coordinator at:

Beacon Health Options
IHA Appeals Coordinator
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801-3393

Questions regarding the fair hearing process may also be directed to the New York State Office of Administrative Hearings at 518.474.8781.

4.6. External Appeal Process

Members or their representatives may have the right to request an External Appeal if their health plan denies coverage because a requested health service is not medically necessary. A member may also request an external appeal if a managed care plan denies coverage for an experimental treatment of a life-threatening or disabling condition. The member, representative or provider must complete Beacon's internal appeal process before requesting an IRO unless the appeal involves a life- threatening condition.

If Beacon denies coverage for the service because it is not medically necessary or because the proposed service is an experimental/investigational treatment, and the denial is upheld upon appeal, Beacon sends the member and provider a letter confirming the denial. This letter is called a notice of Final Adverse Determination, and includes instructions for requesting an external appeal along with an External Appeal Application.

A provider's External Appeal Application to the New York State Department of Insurance within 60 days of receiving the final adverse determination. (If both the provider and Beacon agree, the first level of appeal may be waived and the provider can apply for external review within 60 days of the initial denial of coverage.)

If a delay in rendering a decision would cause harm to the member, the member's primary care physician/provider (PCP) or other physician/provider will need to submit an attestation along with application for an expedited review.

The external appeal agent must render a decision on coverage within 30 days for a standard appeal or 3 days for an expedited appeal. The decision of the external appeal agent is binding on the member, the provider and the plan.

Beacon members are not required to pay any fees related to an External Review.

Participating providers may need to assist a member in completing the External Appeal Application. For appeals that require an urgent decision, providers will need to complete a Physician Attestation Form to be included with the External Appeal Application. The Department of Insurance will review the Physician's Attestation and determine if the matter should undergo an "expedited" external review. Providers may also complete an application to request an External Review of denied coverage for services that have already been provided.

Beacon benefits do not include payment for health care services that are not medically necessary. If a service/drug/device has been determined to be medically necessary through the New York State external review process, Beacon will cover the costs of the service/drug/device to the extent that it would otherwise be covered under the member's health benefit plan.

Similarly, if an external review determines the Beacon should cover an experimental or investigational treatment that is part of a clinical trial, Beacon will cover only the costs of the treatment provided to the member under the terms of the trial. Beacon will not be 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.

To request a New York State External Appeal, send a written request to:

New York State Department of Financial Services
P.O. Box 7209
Albany, New York 12224-0209

You may also contact the New York State Department of Financial Services by calling 800.400.8882 or via email: externalappealquestions@dfs.ny.gov.

Chapter 5

Medical Eligibility

5.1. Member Eligibility

Establishing member eligibility for benefits and obtaining an authorization before treatment is essential for the claims payment process. Your state's Health and Human Services Department is responsible for determining Medicaid. Therefore, if you have Medicaid, please contact your state's Medicaid program to determine eligibility. If you have a commercial insurance, please contact Beacon's Member Services to determine your eligibility. To determine whether you are eligible for Medicare, please visit Medicare.gov or call Beacon's Member Services Department.

5.2. Disenrollment

Your state determines who is eligible for your state's Medicaid program. Your state's Health and Human Services Department (name varies by state) is solely responsible for determining if and when a member is disenrolled and will make the final decision. Under no circumstances can a provider/practitioner take retaliatory action against a member due to disenrollment from either the provider/practitioner or a plan.

There may be instances when a PCP feels that a member should be removed from his or her panel. Beacon requests you contact the member's medical health plan to notify of such requests so that they may arrange educational outreach with the member. All notifications to remove a patient from a panel must be made in writing; contain detailed documentation; and must be directed to the member's medical health plan.

Upon receipt of such request, staff may:

- Interview the provider/practitioner or his/her staff who are requesting the disenrollment, as well as any additional relevant providers/practitioners
- Interview the member
- Review any relevant medical records

Examples of reasons a PCP may request to remove a patient from their panel could include, but not be limited to:

- A member is disruptive, unruly, threatening, or uncooperative to the extent that the member seriously impairs the provider's ability to provide services to the member, or to other members and the member's behavior is not caused by a physical or behavioral condition; or
- If a member steadfastly refuses to comply with managed care, such as repeated emergency room use combined with refusal to allow the provider to treat the underlying medical condition. A PCP should never request that a member be disenrolled for any of the following reasons:
    - An adverse change in the member's health status or utilization of services that is medically necessary for the treatment of a member's condition
    - On the basis of the member's race, color, national origin, sex, age, disability, political beliefs or religion

5.3. Member Rights and Responsibilities

Information pertaining to Member Rights and Responsibilities can be found in the MCO Member handbook.

5.4. Fraud Reporting

REPORTING WASTE, ABUSE, OR FRAUD BY A PROVIDER, CLIENT, OR MEMBERS

Do you want to report waste, abuse, or fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other healthcare providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary
- Not telling the truth about a medical condition to get medical treatment
- Letting someone else use their Medicaid ID
- Using someone else's Medicaid ID
- Not telling the truth about the amount of money or resources he or she has to get benefits

To report waste, abuse, or fraud, choose one of the following:

- You may report directly to Beacon and asking to speak with the fraud investigator.
- You may contact your state's Health and Human Services Department and ask to speak with the fraud investigator.

To report waste, abuse or fraud, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
    - Name, address, and phone number of provider
    - Name and address of the facility (hospital, nursing home, home health agency, etc.)
    - Medicaid number of the provider and facility, if you have it
    - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
    - Names and phone numbers of other witnesses who can help in the investigation
    - Dates of events
    - Summary of what happened
- When reporting about someone who gets benefits, include:
    - The person's name
    - The person's date of birth, Social Security Number, or case number if you have it
    - The city where the person lives
    - Specific details about the waste, abuse or fraud

Chapter 6

Encounter Data, Billing, and Claims

6.1. 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. Providers, please note that Beacon does not accept claims submitted by facsimile.

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

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

DEFINITION OF A "CLEAN CLAIM"

A clean claim, as discussed in this provider manual, the provider services agreement, and in other Beacon informational materials, is defined as one that has no defect and is complete, including required data elements, and when applicable, substantiating documentation of particular circumstance(s) warranting special treatment without which timely payments on the claim would not be possible. All claims received by Beacon will be paid or denied within 30 days of receipt for electronic submissions, and 45 days for receipts of paper submissions.

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.

6.2. Electronic Billing

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

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

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

ADDITIONAL INFORMATION AVAILABLE ONLINE:

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

CLAIMS TRANSACTION OVERVIEW

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

TRANSACTION	EDI	ESERVICES	IVR	APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
Member Eligibility Verification	N	Y	Y	▪ Completing any claim transaction; ▪ Submitting clinical authorization requests	N/A	N/A

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

TRANSACTION	EDI	ESERVICES	IVR	APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
				▪ Provider is eligible for reimbursement retroactively ▪ 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.		reconsideration request. ▪ Beacon's waiver determination is reflected on a future EOB with a message of "Waiver Approved" or "Waiver Denied": if waiver of the filing limit is approved, the claim appears adjudicated; if the request is denied, the denial reason appears.
Request for Reconsideration of Timely Filing Limit*	N	Y	N	Claim falls outside of all time frames and requirements for resubmission, waiver and adjustment	Within the filing limit from the date of payment or nonpayment. Please refer to the health plan-specific contact information at the end of this	Future EOB shows "Reconsideration Approved" or "Reconsideration Denied" with denial reason

TRANSACTION	EDI	ESERVICES	IVR	APPLICABLE WHEN?	TIMEFRAME FOR RECEIPT BY BEACON	OTHER INFORMATION
					manual for the plan's filing limit.	
Request to Void Payment	N	N	N	▪ Claim was paid to provider in error; and ▪ Provider needs to return the entire paid amount to Beacon	N/A	***Do NOT send a refund check to Beacon***
Request for Adjustment	Y	Y	N	▪ The amount paid to provider on a claim was incorrect ▪ Adjustment may be requested to correct: -underpayment (positive request); or -overpayment (negative request)	Positive request must be received by Beacon within the plan's filing limit) from the date of original payment. Please refer to the health plan-specific contact information at the end of this manual for the plan's filing limit. No filing limit applies to negative requests.	▪ **Do NOT send a refund check to Beacon.** ▪ **A Rec ID is required to indicate that claim is an adjustment.** ▪ Adjustments are reflected on a future EOB as recoupment of the previous (incorrect) amount, and if money is owed to provider, re-payment of the claim at the correct amount. ▪ If an adjustment appears on an EOB and is not correct, another adjustment request may be submitted based on the

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

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

Beacon Discourages Paper Transactions

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

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

6.3. 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.

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
10a-c	No	Member's Condition Related to Employment
11	No	Member's Policy, Group, or FICA Number (if applicable)

TABLE BLOCK #	REQUIRED?	DESCRIPTION
11a	No	Member's Date of Birth (MM, DD, YY) and Sex (check box)
11b	No	Employer's Name or School Name (if applicable)
11c	No	Insurance Plan Name or Program Name (if applicable)
11d	No	Is there another health benefit plan?
12	No	Member's or Authorized Person's Signature and Date on File
13	No	Member's Authorized Signature
14	No	Date of Current Illness
15	No	Date of Same or Similar Illness
16	No	Date Client Unable to Work in Current Occupation
17	No	Name of Referring Physician or Other Source (if applicable)
17B	No	NPI of Referring Physician
18	No	Hospitalization dates Related to Current Services (if applicable)
19	No	Additional Claim Information (Designated by NUCC), if applicable. (Record ID if applicable)
20	No	Outside Lab?
21	Yes	Diagnosis or Nature of Illness or Injury. Enter the applicable ICD indicator according to the following: ICD diagnosis
22	No	Medicaid Resubmission Code or Former Control Number
23	No	Prior Authorization Number (if applicable)
24a	Yes	Date of Service
24b	Yes	Place of Service Code (HIPAA-compliant)
24d	Yes	Procedure Code and modifier, when applicable
24e	Yes	Diagnosis Pointer – 1, 2, 3, or 4
24f	Yes	Charges

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

INSTITUTIONAL SERVICES: INSTRUCTIONS FOR COMPLETING THE UB04 FORM

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

TABLE BLOCK #	REQUIRED?	DESCRIPTION
1	Yes	Provider Name, Address, Telephone #
2	No	Untitled
3	No	Provider's Member Account Number

TABLE BLOCK #	REQUIRED?	DESCRIPTION
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
39-41	Yes	Value CD/AMT (If applicable for APG claims)
42	Yes	Revenue Code (if applicable)

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

TABLE BLOCK #	REQUIRED?	DESCRIPTION
66	Yes	ICD Version Indicator
67	Yes	Principal Diagnosis Code
68	No	A-Q Other Diagnosis
69	No	Admit Diagnosis
70	No	Patient Reason Diagnosis
71	No	PPS Code
72	No	ECI
73	No	Unassigned
74	No	Principal Procedure
75	No	Unassigned
76	Yes	Attending Physician NPI/TPI – First and Last Name and NPI
77	No	Operating Physician NPI/TPT
78-79	No	Other NPI
80	No	Remarks
81	No	Code-Code

PAPER RESUBMISSION

- See earlier table for an explanation of claim resubmission, when resubmission is appropriate, and procedural guidelines.
- If the resubmitted claim is received by Beacon more than allowed by the plan's filing limit (please refer to the health plan-specific addendum 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 REC.ID 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 REC.ID corresponds with a single claim line on the Beacon EOB. Therefore, if a claim has multiple lines, there will be multiple REC.ID numbers on the Beacon EOB.

- 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 sheet for the plan's filing limit.

Paper Submission of the Plan's Filing Limit Waiver

Please refer to the health plan-specific Contact Information sheet for the plan's filing limit.

- See earlier table for an explanation of waivers, when a waiver request is applicable, and procedural guidelines.
- Watch for notice of waiver requests becoming available on eServices.
- Download the plan filing limit Waiver Form.
- Complete the plan filing limit Form for each claim that includes the denied claim(s), per the instructions below.
- Attach any supporting documentation.
- Prepare the claim as an original submission with all required elements.
- Send the form, all supporting documentation, claim and brief cover letter to: the Beacon claims address associated with the health plan. Please refer to the health plan-specific Contact Information sheet at the end of this manual for the address.

Completion of the Waiver Request Form

To ensure proper resolution of your request, complete the plan filing limit Waiver Request Form as accurately and legibly as possible. Please refer to the health plan-specific Contact Information sheet for the health plan's filing limit.

1. **Provider Name**
   Enter the name of the provider who provided the service(s).
2. **Provider ID Number**
   Enter the provider ID Number of the provider who provided the service(s).
3. **Member Name**
   Enter the member's name.
4. **Health Plan Member ID Number**
   Enter the member ID Number associated with the member's health plan. Please refer to the health plan-specific addendum for the plan's filing limit.
5. **Contact Person**
   Enter the name of the person whom Beacon should contact if there are any questions regarding this request.
6. **Telephone Number**
   Enter the telephone number of the contact person.

7. **Reason for Waiver**
   Place an "X" on all the line(s) that describe why the waiver is requested.
8. **Provider Signature**
   A plan filing limit waiver request cannot be processed without a typed, signed, stamped, or computer-generated signature. Beacon will not accept "Signature on file". Please refer to the health plan-specific Contact Information sheet at the end of this manual for the plan's filing limit.
9. **Date**
   Indicate the date that the form was signed.

Paper Request for Adjustment or Void

- See earlier table for an explanation of adjustments and voids, when these requests are applicable, and procedural guidelines.
- Do not send a refund check to Beacon. A provider who has been incorrectly paid by Beacon must request an adjustment or void.
- Prepare a new claim as you would like your final payment to be, with all required elements
- Place the Rec.ID in box 19 of the CMS 1500 claim form, or box 64 of the UB04 form

  or

- Download and complete the *Adjustment/Void Request Form* per the instructions below.
- Attach a copy of the original claim.
- Attach a copy of the EOB on which the claim was paid in error or paid an incorrect amount.

Send the form, documentation and claim to the address listed in the health plan-specific Contact Information sheet at the end of this manual.

Completion of the *Adjustment/Void Request Form*

To ensure proper resolution of your request, complete the *Adjustment/Void Request Form* as accurately and legibly as possible and include the attachments specified above.

1. **Provider Name**
   Enter the name of the provider to whom the payment was made.
2. **Provider ID Number**
   Enter the Beacon provider ID number of the provider that was paid for the service. If the claim was paid under an incorrect provider number, the claim must be voided, and a new claim must be submitted with the correct provider ID number.
3. **Member Name**
   Enter the member's name as it appears on the EOB. If the payment was made for the wrong member, the claim must be voided and a new claim must be submitted.
4. **Member Identification Number**
   Enter the plan member ID number as it appears on the EOB. If a payment was made for the wrong member, the claim must be voided, and a new claim must be submitted.
5. **Beacon Record ID Number**
   Enter the record ID number as listed on the EOB.

6. **Beacon Paid Date**
   Enter the date the check was cut as listed on the EOB.
7. **Check Appropriate Line**
   Place an “X” on the line that best describes the type of adjustment/void being requested.
8. **Check All that Apply**
   Place an “X” on the line(s) that best describe the reason(s) for requesting the adjustment/void. If “Other” is marked, describe the reason for the request.
9. **Provider Signature**
   An adjustment/void request cannot be processed without a typed, signed, stamped, or computer-generated signature. Beacon will not accept “Signature on file”.
10. **Date**
    List the date that the form is signed.

6.4. 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:

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

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

6.5. 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.

ADMINISTRATIVE APPEALS PROCESS

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% 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.

COORDINATION OF BENEFITS (COB)

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

- When it is determined that Beacon is the secondary payer, claims must be submitted on paper with a copy of the primary insurance's explanation of benefits report and received by Beacon within the plan's filing limit of the date on the EOB. Please refer to the health plan-specific addendum for the plan's filing limit.
- Beacon reserves the right of recovery for all claims in which a primary payment was made prior to receiving COB information that deems Beacon the secondary payer. Beacon applies all recoupments and adjustments to future claims processed, and reports such recoupments and adjustments on the EOB.

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 record identification number (REC.ID) and the provider's patient account number.

LIMITED USE OF INFORMATION

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

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.

6.6. 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.

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	BILL CLASSIFICATIONS – 2ND DIGIT	FREQUENCY – 3RD DIGIT
1. Hospital	1. Inpatient	1. Admission through Discharge Claim

TYPE OF FACILITY – 1ST DIGIT	BILL CLASSIFICATIONS – 2ND DIGIT	FREQUENCY – 3RD DIGIT
2. Skilled Nursing Facility	2. Inpatient Professional Component	2. Interim – First Claim
3. Home Health Care	3. Outpatient	3. Interim Continuing Claims
4. Christian Science Hospital	4. Diagnostic Services	4. Interim – Last Claim
5. Christian Science Extended Care Facility	5. Intermediate Care – Level I	5. Late Charge Only
6. Intermediate Care Facility	6. Intermediate Care – Level II	6 – 8. Not Valid

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.

Chapter 7

Communicating with Beacon

7.1. 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.

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

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

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

INTERACTIVE VOICE RECOGNITION (IVR)

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

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

ELECTRONIC TRANSACTIONS AVAILABILITY (WHEN BEACON IS A CLAIMS PAYOR)

TRANSACTION/ CAPABILITY	AVAILABLE 24/7		
	ESERVICES	IVR	EDI
Verify Member Eligibility, Benefits, and Copayment	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.

7.3. 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.

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 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.

REQUIRED NOTIFICATIONS

TYPE OF INFORMATION	METHOD OF NOTIFICATION	
	eSERVICES	EMAIL
General Practice Information		
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

TYPE OF INFORMATION	METHOD OF NOTIFICATION	
	eSERVICES	EMAIL
Change in hours of operation	Yes	Yes
Is no longer accepting new patients	Yes	Yes
Is available during limited hours or only in certain settings	Yes	Yes
Has any other restrictions on treating members	Yes	Yes
Is temporarily or permanently unable to meet Beacon standards for appointment access	Yes	Yes
Other		
Change in designated account administrator for the provider's eServices accounts	No*	Yes
Merger, change in ownership, or change of tax ID number (as specified in the PSA, Beacon is not required to accept assignment of the PSA to another entity)	No*	Yes
Adding a site, service, or program not previously included in the PSA, remember to specify: a. Location b. Capabilities of the new site, service, or program	No*	Yes

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

7.4. 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.

7.5. 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.

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.

7.6. Member Eligibility Verification Tools

ONLINE	ELECTRONIC DATA INTERCHANGE (EDI)	VIA TELEPHONE
Beacon's 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. * Please note that this functionality is not targeted to be in place until after Q2 of 2016	Beacon's IVR 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.

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.

Chapter 8

Case Management and Utilization Management

UTILIZATION MANAGEMENT

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

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

Utilization Management program includes processes to address:

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

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

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

1. Individual needs and characteristics of the member include: age, linguistic, or ethnic factors, co-morbidities and complications, progress of treatment, psychosocial situation, and home environment.

2. Characteristics of the local delivery system available to the member include aspects suchas availability of alternative levels of care, benefit coverage for the available alternatives, and ability of local providers to provide all recommended services within the estimated length of stay.

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

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

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

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

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

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

New and Emerging Technologies

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

Treatment Planning

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

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

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

Clinical Review Process

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

prior-*authorization*, *certification*, or *notification*. Beacon may request clinical information at various points in treatment to ensure the ongoing need for care and treatment that is appropriate and effective in improving health outcomes for *members*.

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

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

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

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

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

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

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

Retrospective Review

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

STANDARD DETERMINATION TIME FRAMES

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

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

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

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

Definition of Medical Necessity

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

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

Medical Necessity Criteria

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

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

1. For all Medicare members, first identify relevant Centers for Medicare and Medicaid (CMS) NationalCoverage Determinations (NCD) or Local Coverage Determinations (LCD) Criteria.

2. If no CMS criteria exists for Medicare members and for all non-Medicare members, identify relevantcustom Medical Necessity Criteria.

3. If no custom criteria exists for the applicable level of care and the treatment is substance use related, the American Society of Addiction Medicine (ASAM) criteria would be appropriate.
** Exception: Substance Use Lab Testing Criteria is in InterQual® Behavioral Health Criteria.*

4. If the level of care is not substance use related, Change Healthcare's InterQual® Behavioral HealthCriteria would be appropriate.

5. If 1-4 above are not met, Beacon's National Medical Necessity Criteria would be appropriate.

Beacon has six (6) types of MNC, depending on client or state contractual requirements and lines of

business:

A. Centers for Medicare and Medicaid (CMS) Criteria – National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) contained in the Medicare Coverage Database (https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).

B. Change Healthcare's InterQual Behavioral Health Criteria

C. American Society of Addiction Medicine (ASAM) Criteria

D. NYS LOCADTR 3.0 (Level of Care for Alcohol and Drug Treatment Referral)

E. Custom criteria, including state or client specific levels of care

F. Beacon's National Medical Necessity Criteria

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

Medical Necessity Criteria is available on Beacon's website via hyperlinks whenever possible and is available upon request through the Northeast Service Center e-mail northeastservicecenter@beaconhealthoptions.com. To order a copy of the ASAM criteria, please go to the website www.asam.org/PatientPlacementCriteria.html. In addition, Beacon disseminates criteria sets via the website, provider handbook, provider forums, newsletters, and individual training sessions.

For substance use disorder treatment requests for in-network, OASAS licensed providers, notification of the admission to Beacon is required within two business days from the date of admission. The decision to provide treatment or service to a member is the responsibility of the attending provider and the member (his or her patient). If the requesting provider does not provide the necessary information for Beacon to make a medical necessity determination, Beacon will make a determination based on the information received within the specified timeframes, which may result in an adverse determination. The NYS LOCATDR 3.0 tool with be used for level of care determinations for all OASAS services. The LOCADTR tool is available online at https://extapps.oasas.ny.gov

For in-network providers, treatment requests for all mental health Inpatient, Partial Hospitalization and Intensive Outpatient Program levels of care, notification of admission to Beacon is required within two business days from the date of admission.

As of 01/01/2020, NYS Legislation mandated no UM on Children's Inpatient Mental Health services for individuals 20 and younger for the first 14 days of treatment as long as notification of the admission to Beacon is made within 2 business days. To align with this legislative change, Beacon implemented a Mental Health Notification of Admission (NOA) process for Adult Inpatient Mental Health for in-network providers:

- MH Inpatient (9 day NOA)

and the following for both Adults & Children:

- MH PHP (10 day NOA)
- MH IOP (15 day NOA)

The MH NOA process is for NY in-network providers who submit notification of the admission within 2 business days of the admission date. NY in-network providers who do not submit notification within 2 business days of the admission date, as well as out-of-network providers, will be subject to the standard review process from the time of admission.

Clinical Practice Guidelines

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

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

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

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

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

Clinical Care Manager Reviews

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

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

UM REVIEW REQUIREMENTS – INPATIENT AND DIVERSIONARY

PRE-SERVICE REVIEW	CONTINUED STAY (CONCURRENT) REVIEW	POST-SERVICE REVIEW
The facility clinician making the request needs the following information for a pre-service review: ▪ Member's health plan identification number ▪ Member's name, gender, date of birth, and city or town of residence ▪ Admitting facility name and date of admission ▪ ICD or DSM diagnosis: (A provisional diagnosis is acceptable.) ▪ Description of precipitating event and current symptoms requiring inpatient psychiatric care ▪ Medication history ▪ Substance abuse history ▪ Prior hospitalizations and psychiatric treatment ▪ Member's and family's general medical and social history ▪ Recommended treatment plan relating to admitting	To conduct a continued stay review, call a Beacon UR clinician with the following required information: ▪ Member's current diagnosis and treatment plan, including physician's orders, special procedures, and medications ▪ Description of the member's response to treatment since the last concurrent review ▪ Member's current mental status, discharge plan, and discharge criteria, including actions taken to implement the discharge plan ▪ Report of any medical care beyond routine is required for coordination of benefits with health plan (Routine medical care is included in the per diem rate.)	Post-service reviews may be conducted for inpatient, diversionary or outpatient services rendered when necessary. To initiate a post-service review, call Beacon. If the treatment rendered meets criteria for a post-service review, the UR clinician will request clinical information from the provider, including documentation of presenting symptoms and treatment plan via the member's medical record. Beacon requires only those section(s) of the medical record needed to evaluate medical necessity and appropriateness of the admission, extension of stay, and the frequency or duration of service. A Beacon physician or psychologist advisor completes a clinical review of all available information, in order to render a decision.

| PRE-SERVICE REVIEW | CONTINUED STAY (CONCURRENT) REVIEW | POST-SERVICE REVIEW |

symptoms and the member's anticipated response to treatment ▪ Recommended discharge plan following end of requested service		

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

Inpatient or Higher Levels of Care

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

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

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

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

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

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

Continued stay reviews:

- Focus on continued severity of symptoms, appropriateness, and intensity of treatment plan, *member* progress, and discharge planning

- Involve review of treatment records and discussions with the *provider/participating provider* orappropriate facility staff, *EAP* staff, or other behavioral health *providers* and reference to the applicable medical necessity criteria

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

Effective January 1, 2017, Medicaid managed care plans (MMCPs) are to comply with New York State Insurance Law (INSL) Section 4303(k)(4), as provided by section three of Part B of Chapter 71 of 2016. This section prohibits prior the need for authorization for inpatient substance use disorder (SUD) treatment when provided in a participating OASAS-certified facility. In addition, it prohibits concurrent utilization review during the first 28 days of medically necessary inpatient SUD treatment when providedin a participating OASAS-certified facility, and where the MMCP was notified and received an initial treatment plan from the provider within 48 hours of admission. The OASAS facility is also required to provide periodic clinical updates to the MMCP during the stay.

The statute does not guarantee a member 28 days of treatment. After the initial 28 days, utilization review may be performed for any part of the stay; however, medical necessity denials issued under these circumstances may only be made in accordance with LOCADTR and the Medicaid Managed Care Model Contract.

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

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

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

Discharge Planning

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

- Discharge date
- Aftercare date
  - Date of first post-discharge appointment (must occur within seven days of discharge)
  - With whom (name, credentials)
  - Where (*level of care*, program/facility name)
- Other treatment resources to be utilized:
  - Types
  - Frequency
- Medications
  - Patient/family education regarding purpose and possible side effects
  - Medication plan including responsible parties
- Support systems
  - Familial, occupational and social support systems available to the patient. If key supports areabsent or problematic, how has this been addressed
  - Community resources/self-help groups recommended (note purpose)
- *EAP* linkage
  - If indicated (e.g., for substance use aftercare, workplace issues, such as Return-to-Work Conference, enhanced wraparound services) indicate how this will occur
- Medical aftercare (if indicated, note plan, including responsible parties)
- Family/work community preparation
  - Family illness education, work or school coordination, (e.g., *EAP* and Return-to-Work Conference) or other preparation done to support successful community reintegration. Notespecific plan, including responsible parties and their understanding of the plan.

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

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

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

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

When requested, please:

1. Have the patient complete the *authorization* form, with help if needed.

2. Send the *authorization* to Beacon by faxing it to the number on the form.

3. Schedule a discharge appointment within seven days after discharge. If you need help with getting an appointment within seven days, please contact Beacon.

For further information on how to refer a member to case management, please contact Beacon Health Options Member Services, 855-481-7038.

Health Plan-Specific Contact Addendum

HEALTH PLAN INFORMATION

Health Plan Name: Independent Health®

Health Plan EDI Code: Emdeon ID - 4332447

BEACON CONTACT INFORMATION

Beacon Hours of Operation: M-F 8:00 am – 6:00 pm; Emergency line open 24/7

Beacon Ombudsperson: 844.265.7592

Beacon TTY: 866.727.9441

Beacon's Member Services/Clinical Appeals Coordinator: 844.265.7592

Beacon's Provider Relations: 844.265.7592

Interactive Voice Recognition (IVR): 888.210.2018

Beacon Claims Department: 844.265.7592

Beacon Claims Department
500 Unicorn Park Drive
Woburn, MA 01801

CLAIMS TIMING INFORMATION

Plan/State required filing notice limit: Medicaid (MediSource 90 day EP/CHP 120 day)

Time limits for filing inpatient claims: 120 days

Time limits for filing outpatient claims: 120 days

Number of days from determination to request for a fair hearing: 60 days

GOVERNMENT CONTACT INFORMATION

State Fair Hearing Office

NYS Office of Temporary and Disability Assistance

Office of Administrative Hearings Managed Care Hearing Unit

P.O. Box 22023

Albany, NY 12201-2023

By Fax: 518.473.6735

For additional information, visit:

https://otda.ny.gov/hearings/

To request in person:

Office of Temporary and Disability Assistance

Office of Administrative Hearings

40 North Pearl Street, 15th Floor

Albany, NY 12243

State External Appeals Office

Mailed requests:

NYS Department of Financial Services

P.O. Box 7209

Albany, NY 12224-0209

By Fax: 800.332.2729

If an appeal is expedited, you must call 888.990.3991 to tell us.

For additional information, visit:

http://www.dfs.ny.gov/insurance/extapp/extappqa.htm